

Holgate House Limited

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

The location was registered to provide accommodation for people requiring treatment for substance misuse.

This was an announced comprehensive inspection. We also looked again at issues identified at a previous inspection.

Following the last inspection in January 2016, we issued requirement notices relating to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The breaches were in relation to:

- Regulation 5: Fit and proper persons: directors
- Regulation 12: Safe care and treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

At this inspection, we assessed whether the service provider had made improvements to the issues we identified in the requirement notices. We found that the provider had made the improvements and had met the requirement notices.

Summary of findings

At the last inspection in January 2016, we also found areas that the provider should take steps to improve. These were:

- The provider should ensure that staff members are not line managed by a person to whom they are related.
- The provider should ensure complaints relating to family members are investigated independently.
- The provider should ensure complaints information is accurate and appropriate.
- The provider should ensure that staff have a clear understanding of the principles of the duty of candour.
- The provider should ensure that they are only registered for regulated activities that they provide.

During this inspection we were assured by looking at records and speaking with staff on duty that the provider had taken steps to ensure that these areas had been addressed.

We found the following areas of good practice:

- The environment was very clean, well maintained, welcoming and comfortable.
- Staff managed risk effectively. They identified risks for clients on admission. All clients had detailed risk management plans and staff reviewed the risks regularly according to the level of risk.
- Staff had a good understanding of the duty of candour.
- Clients were involved in decisions about their care and the service. There were agreed house rules and a behavioural code of conduct.
- Staff carried out assessments before clients were admitted to ensure that the service could meet their individual needs.

- There was a structured programme of care, therapy and activities. Discharge planning included an aftercare package to support clients following rehabilitation.
- Care plans were recovery focused. They were comprehensive and detailed. In the records we examined, it was clear what the client's goals were and how they would achieve them. The service and clients reviewed the care plans regularly together.
- Care and treatment was underpinned by best practice. Clients had access to psychosocial therapies, group sessions and individual one to one sessions with a counsellor.
- Staff worked with clients to help them develop the skills they needed to sustain their recovery and maintain their independence when they returned to the community.
- Staff established therapeutic relationships with clients and involved them in their care.
- Staff treated clients with respect and kindness and supported them throughout their stay.
- There was a structured programme for staff supervision and appraisal of work performance.
- Staff we spoke with were highly motivated in their work and told us they felt very well supported by senior management. There was an open and transparent culture. Staff told us they felt comfortable raising any concerns or issues.
- Staff had a good understanding of the statutory principles of the Mental Capacity Act 2005. The provider had a Mental Capacity Act policy to provide guidance for staff.
- There were effective systems and processes to ensure that the provider complied with the fit and proper person requirements.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		See overall summary

Summary of findings

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Holgate House Ltd

Services we looked at:

Substance misuse services

Summary of this inspection

Background to Holgate House Limited

Holgate House is a residential rehabilitation service for up to 22 adults with a history of drug and/or alcohol dependency. There were 21 clients on the day of our inspection. The service is registered with the Care Quality Commission to provide accommodation for persons who require treatment for substance misuse.

In April 2016 the provider cancelled their registration for treatment for disease, disorder and injury in line with regulatory requirements as they did not provide this regulated activity at, or from, this location.

The service has a registered manager.

Most clients were funded via commissioning arrangements.

The service is based in the Ribble Valley. Accommodation is provided across two neighbouring houses in the same grounds, one accommodating 10 clients, the other 12. There is a mix of six double and 10 single rooms. Clients undertake a rehabilitation programme based on the 12-step framework and person centred cognitive therapy.

The Care Quality Commission has inspected Holgate House four times. The last comprehensive inspection was in January 2016.

Our inspection team

The team that inspected the service comprised CQC inspector Annette Gaskell (inspection lead) and two other CQC inspectors.

Why we carried out this inspection

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

We also checked to find out whether the provider had made improvements since our last inspection in January 2016 and had taken action to rectify the concerns identified in the requirement notices.

The provider sent us an action plan dated 28 July 2016 telling us what improvements they would make to ensure the regulations were met. This included:

- Introducing risk management plans and a process for monthly review.
- Introducing processes to ensure care plans were individual and reviewed monthly.
- Introducing a Mental Capacity Act policy to provide guidance for staff.
- Ensuring all staff received training on the Mental Capacity Act.
- Introducing processes to ensure directors were fit, and that no appointments meet any of the unfitness criteria set out in the regulations.
- Appointing an external supervisor.

How we carried out this inspection

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

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

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location and considered the action plan sent by the provider following our last inspection.

During the inspection visit, the inspection team:

- visited both houses at this location, looked at the quality of the physical environment and observed how staff were caring for clients
- spoke with two clients
- spoke with the registered manager
- spoke with both directors
- spoke with two other staff members employed by the service provider including a group facilitator and assistant manager
- attended and observed a hand-over meeting
- attended and observed a group therapy session
- looked at four care and treatment records
- looked at policies, procedures and other documents relating to the running of the service
- spoke with a representative of the external organisation appointed to provide independent supervision and complaints investigations.

What people who use the service say

We spoke with two clients who used the service. Most were engaged in treatments and group work throughout the inspection.

Clients were very positive about the service and the treatment they had received. They said the staff were

compassionate and supportive, that staff always listened to them and supported their recovery. Clients told us they were involved in planning their care and treatment and had confidence in the staff. They were very positive about the impact the service had on their lives.

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 areas of good practice:

- The environment was clean and well maintained.
- There were sufficient staff to deliver the treatment programme.
- Staff demonstrated understanding of procedures for safeguarding clients from abuse. The managers acted as safeguarding leads.
- Staff had completed core skills training to their required level.
- Staff managed risk effectively. Clients had detailed risk management plans and staff reviewed their risks regularly.
- There was a policy outlining the duty of candour that provided guidance for staff. We were assured by speaking with staff that they understood the principles of the duty of candour.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Care plans were comprehensive and detailed. In the records we reviewed it was clear what the clients' goals were and how they would achieve them. Staff reviewed the care plans at least monthly with each client according to the level of risk.
- Staff carried out assessments before clients were admitted to ensure that the service could meet their individual needs.
- Care and treatment was underpinned by best practice. Clients had access to psychosocial therapies, group sessions and individual one to one sessions with a counsellor.
- Staff supported clients to build the skills required to help them function and maintain their independence when they returned to the community.
- Staff received training to ensure they understood the statutory principles of the Mental Capacity Act 2005.
- The service had a Mental Capacity Act policy that provided guidance for staff.
- Staff received regular supervision and appraisal.
- The provider had appointed an external organisation to provide supervision for staff who had a familial relationship with their line manager.

Are services caring?

We do not currently rate standalone substance misuse services.

Summary of this inspection

We found the following areas of good practice:

- Staff established therapeutic relationships with clients and involved them in their care.
- Clients' emotional and social needs were highly valued and respected.
- Staff treated clients with respect and kindness and supported them throughout their stay.
- Clients developed their own treatment goals and objectives.
- Clients had opportunities to feed back to staff and raise any issues.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There was a structured programme of care, therapy and activities. Discharge planning included an aftercare package to support clients following rehabilitation.
- The welcome pack and complaints policy provided information about how clients could make a complaint.
- The provider had appointed an external organisation to carry out independent investigations into complaints.
- The provider identified clients' specific diverse needs through the assessment process and planned care in order to meet those needs.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There were effective systems and processes to ensure good governance.
- There was a structured approach to supervision and appraisals.
- Staff we spoke with were highly motivated in their work and told us they felt supported by senior management. There was an open and transparent culture. Staff told us they felt comfortable raising any concerns or issues.
- Staff were committed to the organisations' vision and values.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a Mental Capacity Act policy that provided guidance for staff.

Since our last inspection, all staff had completed Mental Capacity Act training.

We looked at minutes of team meetings that contained evidence of discussion about the Act. Staff had signed the minutes to indicate that they had read and understood them.

We discussed mental capacity with the staff on duty. The staff we spoke with gave examples where they would consider a client's capacity and the action that they would take. Staff told us that concerns regarding capacity were rare. The provider did not admit clients who lacked

capacity as they would be unable to engage with the treatment programme. The provider did not formally reconsider capacity but staff would report any concerns about a client's capacity to the provider, who would liaise with the funding local authority to arrange a capacity assessment depending on the decision required.

Staff referred to the policy guidance in our discussions and told us that if they needed any advice on decisions around capacity they would know where to access it.

We were assured that staff understood the statutory principles of the Mental Capacity Act 2005 and the application of the Act within their roles.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Holgate House service was split over two residential buildings in the same grounds that accommodated 22 clients in total. Both premises were clean and well maintained. Clients cleaned the buildings every day according to a rota.

There were a clear set of house rules and a behavioural code of conduct that clients entering the service were required to agree to as part of their admission. Staff and clients discussed the rules at weekly house meetings. The service allocated clients three 'lives'. A breach of the house rules and code of conduct could result in a life being lost. Lost lives could be reinstated after a month if there had been no further breaches. The house rules worked alongside the treatment programme. They encouraged clients to take an outward-looking approach and promoted responsibility for themselves and towards others.

Bedrooms were on the first floor in each building. There was no lift to support access for clients with physical disabilities. The provider told us that commissioners were aware of this and did not refer clients with mobility issues that prevented them from using stairs.

Bedrooms were both single and dual occupancy. Where bedrooms were shared this was on a strict same gender basis. Males and females were accommodated on separate corridors. The provider did not allow sharing a bedroom with a client of the opposite gender. This ensured clients' privacy and dignity were safeguarded. Unless a risk assessment indicated otherwise, the provider allocated new admissions to a shared bedroom with a 'senior peer'. A senior peer was a client who had been in the service for a period of time and could help the new client settle. The provider informed clients that they would be in a shared

bedroom prior to admission and they were able to visit the facility to see this arrangement. Clients could lock their bedrooms and the provider did not allow them to go into each other's bedrooms. This was to respect each client's right to privacy and dignity.

Bedrooms had washing facilities but did not have ensuite showers or baths. There were separate showers and bathing facilities on each corridor.

There were visible ligature points in the building and in bedrooms. The provider told us they did not admit clients with high level mental health concerns or who were deemed to be at risk of self-harm. There were environmental risk assessments that included fire risk assessment, water temperatures and infection prevention and control. Staff also completed a risk assessment with each client on admission.

A member of staff was responsible for building maintenance and governance. There were up to date risk assessments for health and safety, legionella and fire. The service had addressed identified actions. Staff had received fire safety training. All staff members had completed first aid training. This meant there was a first aider on site at all times.

Safe staffing

The staffing establishment included support workers, group facilitators and team leaders. One of the directors and the registered manager were also therapists. The deputy manager also acted as the social co-ordinator and carried out assessments prior to admission.

There were three person centred therapists and two group facilitators. One of the group facilitators acted as team leader. There were an additional three support workers, a finance officer and an administrator. In addition, a director was on site and assisted when required. There was a student social worker on placement. One support worker

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had left since we last inspected and the post was vacant. There was no staff sickness. The service did not use agency staff. The service arranged cover from a bank within the existing staffing establishment. Annual leave was booked a month in advance so that cover could be arranged. Unplanned absences were managed by the goodwill of the team.

Day time staffing incorporated the manager, two counsellors and the social co-ordinator, plus a support worker and group facilitator in each house. There was a sleep over shift that comprised of one staff member per house.

There was a programme of mandatory training. This included the Mental Capacity Act 2005, fire safety, health and safety, equality and diversity, first aid and medicines administration training. The service used a training matrix to monitor compliance and record renewal dates. Staff were compliant with all mandatory training. The group facilitators and support workers had either completed or were working towards an NVQ level two certificate in health and social care.

Assessing and managing risk to clients and staff

Since our last inspection, the provider had introduced appropriate systems and processes to ensure that all clients had a comprehensive, individual risk assessment on admission that informed a risk management plan and that staff carried out regular reviews.

We reviewed four clients' files. The files all contained a comprehensive risk assessment.

Risk assessments were detailed and captured all relevant information. For example, there was space to capture concerns relating to mental health, mental capacity, self-neglect, dietary concerns, smoking, alcohol and drug use. Staff categorised risks as low, medium or high and then decided the frequency of review from this. Staff reviewed some risk assessments weekly or fortnightly but all were reviewed at least monthly.

The information from the risk assessment had been used to develop an individual risk management plan for each client. The risk management plans all contained a summary of the risk assessment then went on to state each identified risk and the level of that risk. Staff had identified triggers to individual risks and mitigating action to take.

The plans contained the name of the staff responsible and a review date. All had been updated at least monthly and signed by staff and clients. Staff reviewed each client's care record every month and the manager signed off the review.

We reviewed minutes of staff meetings. All staff had discussed the new system and reviewed it at subsequent meetings to ensure the process was effective.

The service had a policy for when a client left the service unexpectedly through self-discharge. Where possible, clients were provided with seven days' supply of medication. The client's care co-ordinator and next of kin were informed.

The service did not prescribe medication. However, it stored and helped dispense medications that had been prescribed for clients by other health professionals. This included prescribing for physical and mental health issues by GPs. There was a policy to support this, and links with a local pharmacy that delivered medications. Staff received training on medications management. The policy covered the ordering, storage and dispensing of medications. This included the confirmation of medication and identification of the client prior to dispensing. Medications were secured safely in a locked cupboard. There was a process for medicine reconciliation and monthly audits to check stock levels.

Staff received safeguarding training as part of their induction and mandatory training. Senior management were identified as safeguarding leads and provided advice and support. The provider had good links with local safeguarding authorities. There were policies that provided staff with guidance for the safeguarding of both adults and children. Staff signed to confirm that they had read the policies. The service had not raised any safeguarding alerts in the previous 12 months.

Track record on safety

In the 12 months prior to our inspection there had been no serious incidents that required investigation.

Reporting incidents and learning from when things go wrong

There was a policy to guide staff in reporting accidents and adverse incidents. There was a paper form used for reporting incidents. There was a separate accidents book to record accidents. There had been no adverse incidents or accidents reported in the previous 12 months. The policy

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included guidance on reporting of injuries, diseases and dangerous occurrences regulations. We discussed incident reporting with staff. They were aware of the policy and referred to it in our discussions. They understood how to respond to an incident.

Duty of candour

During this inspection, we found the provider had introduced a policy outlining the duty of candour that provided guidance for staff. The policy set out the provider's approach to the duty of candour and what action it would take if an incident occurred that prompted the duty. There was a clear culture of transparency in the service. The provider encouraged staff to be open and honest if something went wrong. We discussed this with the staff and the directors on duty. We looked at minutes of team meetings that contained evidence of discussion about the duty of candour. Staff had signed the minutes to indicate that they had read and understood them. We were assured that they understood the principles of the duty of candour and had the skills necessary for them to carry out their roles. There had been no incidents that met the duty of candour threshold in the twelve months before this inspection.

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

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

We examined four patients' care records. Staff completed an assessment for each client prior to admission. This allowed staff to ensure that the service could meet the individuals' needs. In all four records, we found that staff had developed a care plan and there was clear evidence that the client had been involved in the process. The care plans were goal and recovery focused. Goals were set with a realistic timeframe, for example, taking a more active role in group work. Staff and clients reviewed goals together at least every month and there were daily updates in the progress notes. They covered a range of issues such as physical and mental health, social, spiritual and financial needs. They looked at barriers to achieving goals and the support needed to realise them, including clients' own strengths. Staff had considered individual diverse needs and offered copies of the care plan to the client.

Physical health care concerns were addressed.

All the records had been updated at least monthly and staff and clients both signed them. Staff also peer reviewed each client's care record every month to ensure they were complete and the manager signed off the review.

Best practice in treatment and care

Holgate House delivered care in line with the 12-step programme. The 12-step programme was developed by the alcoholics anonymous fellowship. It utilises principles of mutual aid and peer support. The National Institute for Health and Care Excellence has produced guidance for services managing clients with substance misuse issues, such as guidance on drug misuse in over 16s: psychosocial interventions (NICE CG51) and guidance on alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE CG115). The guidance recommends that clients have access to mutual aid (self-help) support groups normally based on 12-step principles.

Clients were able to access cognitive behavioural therapy and person centred counselling sessions. Cognitive behavioural therapy is a talking therapy that helps individuals manage their problems by changing the thoughts and behaviour associated with them. Counsellors followed guidelines from the federation of drug and alcohol professionals.

Clients completed a significant event form and a feelings diary each day. This enabled them to reflect on the day, looking back at what had happened and what they had learnt from that. Staff were available to discuss any concerns clients may have identified in this process. The forms and diaries were also used to help structure therapy and counselling sessions.

The provider worked with clients to help them develop recovery capital. Recovery capital refers to social, physical, human and cultural resources a client needs to develop to help them achieve and sustain their personal recovery. Clients told us that the groups and sessions they attended had helped them understand and manage their health and social needs. They were able to explore the reasons behind their substance misuse and develop coping strategies. Clients linked in with other organisations and were encouraged to develop their social support including

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mutual aid. Sessions also included life skills such as cooking. These helped clients build the skills required to help them function and maintain their independence when they returned to the community.

Holgate House did not provide a physical health service and had links with a local GP to manage physical health concerns. The service had an effective relationship with the GP and encouraged clients to register as patients. Staff supported clients to attend appointments at the GP, dentist or other health appointments as required.

The service did not have a formal audit programme. However, staff carried out monthly audits on medication stored at Holgate House. This included stock checks to ensure medications had not been lost or misplaced. They also carried out monthly peer review of all care records and the review was signed off by the manager.

Holgate House measured outcomes using the national drug treatment monitoring service. The national drug treatment monitoring service is managed by Public Health England. It collects, collates and analyses information from those involved in the drug treatment sector. All drug treatment agencies must provide the national drug treatment monitoring service with a basic level of information on their activities each month. Providers are able to access reports and compare performance against the national picture. Holgate House's data submissions over the 12 months up to 24 October 2016 showed a successful completion rate of 69%.

Skilled staff to deliver care

Staff had the necessary skills to carry out their duties. Counsellors had diplomas in person-centred counselling. Support workers had either completed or were working towards an NVQ level 2 certificate in health and social care. Group facilitators and support workers had their own experience of addiction and recovery. This helped staff to develop relationships with clients.

Staff were able to access additional training if it was identified as a need or part of service development. For example, two staff members had completed aromatherapy courses. This was intended to help support clients who had difficulties sleeping. The service supported another member of staff to complete a foundation degree in mental health. The manager had completed a diploma in management.

All staff received regular supervision on a monthly basis. Records we saw confirmed this. There was a structured programme of supervision and a set agenda for sessions. Notes of the supervision session were signed by both the supervisor and supervisee. Staff also received an annual appraisal and set annual objectives.

During this inspection we found that external supervisors had been appointed to provide managerial and clinical supervision to staff who had a familial relationship with their line manager. We spoke with a representative of the external organisation appointed to carry out supervision and they explained their role. This helped ensure supervision and appraisal of these staff remained objective.

Multidisciplinary and inter-agency team work

Staff attended a handover meeting before and at the end of each shift. We observed one handover meeting during the inspection. The handover was thorough and comprehensive. Staff reviewed each client's presentation and discussed in detail, including the support they needed. Staff showed a good knowledge of the clients and worked together to deliver care.

Staff remained in contact with referring agencies during clients' treatment and informed them of discharge plans.

The service had strong links with other local recovery communities. These included alcoholics anonymous, narcotics anonymous and local recovery infrastructure organisations. This meant clients had opportunities to build sustainable recovery capital in community based settings. Clients were supported to access community organisations and volunteering opportunities. Staff also supported clients to attend social events, such as a juice bar set up by a recovery group in the local community, with bands and DVD nights.

Adherence to the MHA

The service did not admit clients detained under the Mental Health Act 1983. If a client's mental health were to deteriorate, staff were aware of who to contact.

Good practice in applying the MCA

Substance misuse services

The Mental Capacity Act 2005 is a piece of legislation that enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves.

The provider had introduced a Mental Capacity Act policy to provide guidance for staff. The policy set out what action it would take if there were concerns about a client's capacity. It advised staff how to report any concerns and who to.

We looked at minutes of team meetings that contained evidence of discussion about mental capacity and the new policy. Staff had signed the minutes to indicate that they had read and understood them.

We looked at staff training records. Since our last inspection, all staff had completed Mental Capacity Act training. Mental Capacity Act training was part of the mandatory training programme. The provider used an electronic training matrix to monitor compliance and record renewal dates.

We discussed mental capacity with the staff on duty. We were assured that they understood the statutory principles of the Mental Capacity Act 2005 and the application of the Act within their roles. They gave examples where they would consider a client's capacity and the action that they would take. Staff told us that concerns regarding capacity were rare. The provider did not admit clients who lacked capacity, as they would be unable to engage with the treatment programme. The provider did not formally reconsider capacity but staff would report any concerns about a client's capacity to the provider, who would liaise with the funding local authority to arrange a capacity assessment depending on the decision required.

Staff referred to the policy guidance in our discussions and told us that if they needed any advice on decisions around capacity they would know where to access it.

There were no clients subject to deprivation of liberty safeguards.

Equality and human rights

There was an equality and diversity policy that covered protected characteristics under the Equality Act 2010 and definitions of discrimination and inclusion. It also gave

examples of how equality, diversity and inclusion related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, such as respect for personal preferences, lifestyle choices and

helping to celebrate events, anniversaries or festivals which were important to them as individuals.

We looked at staff training records. All staff had completed equality and diversity training. Equality and diversity training was part of the mandatory training programme. The provider used an electronic training matrix to monitor compliance and record renewal dates.

One client we spoke with told us they had specific diverse needs and they were clear that staff respected their needs. Another did not have specific needs but they felt that staff would respect and respond to individuals that did. For example, all clients were involved in planning the weekly menus, including culturally appropriate diets if necessary. The client's family could bring in some food, for example, kosher food.

The service had some blanket restrictions. There was a blanket restriction on the use of drugs or alcohol. There was also a blanket restriction on visits by individuals in active addiction. Clients were not allowed televisions, radios or stereo equipment in their rooms. They were able to watch television within communal areas but this was restricted to set times.

Clients were not allowed to make their own meals outside the planned rota. They were able to access drinks and snacks outside the rota but were not allowed to take these into groups.

Clients were unable to make phone calls or receive visits during the first week of treatment.

Clients were not allowed to bring mobile phones into Holgate House. However, they were able to make telephone calls using telephone facilities in the communal areas and they could make private calls using the telephone in the staff office.

These restrictions were appropriate due to the nature of the service. They were intended to ensure clients focussed on their treatment. Staff explained the restrictions to each client prior to admission and they were included in the residents' handbook.

Substance misuse services

Management of transition arrangements, referral and discharge

The service accepted referrals from individuals and any other organisation, for example, NHS and third sector substance misuse services, GPs, local health and support agencies. The service carried out an assessment and liaised closely with referring agencies to ensure the referrals were appropriate. A decision was made within 24 hours of assessment. Funding was arranged with local authority commissioners before a place was offered. We spoke with two clients. Both felt that the transition from their previous service was well managed.

There was a clear process for discharge. After three months in the treatment programme, staff discussed discharge with the client in their personal development meetings. They held a review meeting with each client a month before their discharge. The meeting included the client, key worker and the client's care co-ordinator. The meeting was used to confirm agreed aftercare plans and discuss any outstanding actions or issues from the client's care plan. The service also offered a weekly follow on support group and residential second stage treatment in local accommodation. These options were not obligatory and clients could make other choices if they wished.

Records we reviewed showed that the service worked with other agencies to facilitate access and discharge. We spoke with two clients. Neither were close to discharge and did not have a formal discharge plan. However, they both understood the process for discharge and knew that discussions and a formal plan would be developed closer to their discharge.

There was a clear process for managing unplanned exits from treatment. Staff would inform the care co-ordinator and next of kin. If a client decided they wished to leave over the weekend, staff would try to persuade them to stay until services re-opened on Monday so that relevant agencies could be informed before they left. Staff would ask the client to sign a discharge form. With the client's agreement, staff would contact their family and arrange for them to be collected or dropped off.

Are substance misuse services caring?

Kindness, dignity, respect and support

We observed positive interactions between staff and clients. Clients were treated with compassion and understanding. They told us they felt supported emotionally and practically. Staff were approachable and engaged with individuals in a respectful and dignified manner. They showed a good understanding of individual need and circumstance. They were person centred in their approach and able to use their own experiences of substance misuse to engage with clients and develop effective therapeutic relationships. A therapeutic relationship is a relationship between a worker and a client that is built on mutual trust and respect with the aim of bringing about beneficial change.

The service had a confidentiality policy. The importance of confidentiality was discussed with clients during admission.

The involvement of clients in the care they receive

There was an admission process to inform and orientate clients to the service. Clients were able to visit prior to admission to view the service and speak to staff and peers. This allowed the client to ensure that the service was appropriate for them before admission. The service provided a welcome pack for clients, which included information on the service, its aims and objectives, house rules, expected standards of behaviour and the complaints process. A sample copy of the activities schedule was also provided.

Clients told us how they were actively involved in their treatment. They identified that they had developed their own sets of goals and objectives. Where they had requested the involvement of family members or carers this had been facilitated. The provider did not allow clients to have visitors in the first week of their admission. This was to ensure they were able to focus on their treatment. Staff explained this to clients before admission. Family visits were allowed after that but only at weekends and at a set visiting time.

There were weekly house meetings. This gave clients the opportunity to feed back to staff and to raise any issues. We saw evidence of staff responding to concerns. For example, in one meeting two clients had asked for fans, as they felt hot in their bedrooms. The service had provided these.

All clients were asked to complete a questionnaire when they were discharged. This gave clients an opportunity to

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give feedback on the service they had received. Senior management reviewed the questionnaire responses. Clients told us they were also able to feed back issues informally to staff on a day-to-day basis.

The provider had also received 20 compliments in the 12 months prior to this inspection.

Clients could contact a local advocacy service if they wished. Those we spoke with said they had no need of an advocate.

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

Access and discharge

Holgate House worked with people aged 18 years and over who had a history of misusing alcohol or drugs.

All clients completed a detoxification programme prior to entering the service. This meant that clients were able to benefit from the rehabilitation treatment. The admission process began prior to detoxification. An external organisation helped clients to choose their preferred rehabilitation service. They were able to visit the service and speak to the staff and clients. This enabled the service to explain how the treatment programme worked and ensure that the individual understood the underpinning philosophy. This included an explanation of the house rules and expected standards of behaviour. Clients were required to consent and accept these rules before the provider offered a placement. They also received a copy of the clients' welcome booklet, which provided further information. This meant they were able to decide if the service suited their own needs before making their choice.

Staff worked with each client's care co-ordinator to identify an admission date in conjunction with the planned detoxification. Clients attended immediately following detoxification and staff would pick them up from their detoxification service. Clients we spoke with told us that their transfer had been quick and easy.

Clients' length of stay depended on the amount of funding available for them from commissioners. Most clients stayed for four to six months. The national mean average time in treatment was 332 days across the four substance groups. Discharge planning began on admission and a formal

discharge plan was developed in the few weeks leading up to the client leaving the service. Staff worked with the client and referral agency to plan discharge dates. Clients were encouraged to consider their objectives following discharge and staff supported them in meeting these. This included developing support networks, coping strategies and recovery capital. There were opportunities for clients to stay in accommodation owned by the managers and receive aftercare provided by the organisation. Staff also supported clients in identifying mutual aid groups within the area.

The service submitted data to the National Drug Treatment Monitoring System, which local and national commissioners use to compare substance misuse services and their outcomes. Planned completions for clients from treatment, where clients do not represent back to the service within six months, is one of the outcomes that is used to measure the success of a service. Completion is determined by clinical judgement that the individual no longer has a need for structured treatment, having achieved all the care plan goals and having overcome dependent use of the substances that brought them into treatment. Fifty-three of 74 clients had successfully completed treatment in the 12 months up to 24 October 2016. This represented 69% of the client population. The service was performing better than the national average of 50% for clients successfully completing treatment across the four substance groups.

Following their discharge, clients were able to access the weekly support group. This allowed the service to ensure that the client was safe and well. Clients were able to get advice and support around any issues that they may have been experiencing post discharge. They also had the opportunity to become peer mentors.

The facilities promote recovery, comfort, dignity and confidentiality

Holgate House was situated in a rural location that provided a peaceful environment for clients to work on their recovery. There were communal areas and lounges as well as confidential areas used for group work and therapy sessions. There was access to well-maintained outdoor spaces.

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Clients were expected to live and function as part of the house community. They cooked for the house and adhered to a cooking rota. Drinks and snacks were available at other times.

Clients were able to personalise their bedrooms by displaying photographs and posters providing these were not offensive. All bedrooms had secure storage spaces that clients could use. Clients were also able to give personal items to staff for safe storage.

There were activities for clients seven days a week. There was an activity rota displayed for clients. Activities varied from 12-step based lectures and group sessions to communal and social activities such as quizzes and group walks. The rehabilitation programme included free time and dedicated time for clients to spend with their key worker. There were meditation sessions every morning. Some staff were also trained to provide complementary therapies such as aromatherapy. Clients we spoke with told us that they found the activities beneficial and relevant to their needs.

The service also facilitated monthly trips that staff discussed and agreed with the clients, such as a trip to the local bowling alley.

Meeting the needs of all clients

Holgate House was not able to provide treatment to individuals with reduced mobility. They stipulated this in the referral information, and referral agencies were aware of this restriction. This was because the premises were listed, which meant the provider could not make appropriate alterations.

Information on local services and recovery projects was on display and available within the service. This helped clients to develop their recovery capital and support network.

Cultural and religious needs were identified through the assessment process. This allowed the service to identify in advance whether services, such as interpreters, were required and to work with the client, their care co-ordinator and local services to provide this.

One of the clients we spoke with told us they had specific diverse needs and they were clear that staff respected their needs.

Staff would support clients to attend local places of worship if this was requested. Holgate House accepted

individuals with a range of religious beliefs provided they did not contradict the 12-step ethos. Staff could arrange for specific dietary requirements relating to religious or physical health requirements, or translation for clients whose first language was not English. They identified such needs in the assessment process, which provided time for the service to address needs before the client's admission.

Listening to and learning from concerns and complaints

During this inspection, we looked at the complaints policy and the welcome pack. We found the provider had made amendments so that the information was accurate and directed clients to the appropriate body if they were unhappy with the outcome of a complaint. The policy covered both verbal and written complaints.

There was a complaints book to capture both verbal and written complaints. There had been no complaints in the 12 months prior to this inspection.

Staff received training on dealing with complaints as part of their induction. We looked at minutes of team meetings that contained evidence of discussion about complaints and the amended policy. Staff had signed the minutes to indicate that they had read and understood them. We were assured that they understood the complaints process.

The provider had appointed an external organisation to investigate complaints related to a member of the family. We spoke with a representative of the organisation who explained their role. This helped ensure that investigations into such complaints were objective.

Are substance misuse services well-led?

Vision and values

Holgate House had a mission statement. The mission statement was to help, support and empower clients ongoing abstinence from drug and alcohol dependency whilst exploring opportunity for personal growth and development. Staff were aware of the mission statement.

The service had a set of objectives that were set out in the information handbook. These were:

- to provide help in which residents can develop existing life skills and remedy skill deficiencies

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- to assist in the service user's personal development and encourage self-esteem, including assisting them to develop specific coping strategies
- to offer help in ways that respect the individuality of each service user and their race, culture, religion, disability and sexual orientation.

Senior staff were a visible presence and part of the team. Staff told us they were approachable and operated an open door policy.

Good governance

There were effective systems and processes to ensure that the provider complied with the fit and proper person requirements.

There was a document in relation to the fit and proper person test that the provider adhered to in order to ensure its directors were of good character, had sufficient health to be able to fulfil their role with reasonable adjustments and had the appropriate skills, knowledge and experience to complete their roles. The document set out checks required to satisfy the regulation.

Both directors' files contained a medical reference from their GP and a current disclosure and barring service check. This check ensured that directors were of good character and had no criminal convictions that would make them unsuitable to work with the clients in the service. The provider had also completed other checks, for example, anti-money laundering, and had taken up references. Both directors had completed the mandatory training programme.

There was a structured programme for induction, regular supervision and annual appraisal for all staff. There was an agreement with an external organisation to provide managerial supervision to staff who had a familial relationship with their line manager. Staff who had family links also received clinical supervision from an external supervisor.

Staff had access to a programme of mandatory training and were able to request additional specialised training. The service had a range of policies and procedures for

guidance, which staff were required to read and then sign to demonstrate their understanding. Staff attended team meetings where they received up to date service information.

We reviewed two staff files. Appropriate checks had been carried out before employment. These included references, copies of qualifications and certificates to confirm staff were appropriately skilled in line with their job description and disclosure and barring service checks.

There were systems that captured risks. For example, environmental assessments captured relevant risks and included control measures and actions to reduce or remove the risk.

Leadership, morale and staff engagement

Staff we spoke with were highly motivated in their work. They felt supported by senior management. Staff told us that they enjoyed their jobs and found them rewarding.

There was no staff sickness. There was one support worker vacancy. Staff turnover for the previous 12 months had been 20%. There had been no bullying or harassment cases reported at the service.

There was an open and transparent culture. Staff told us they felt comfortable raising any concerns or issues with senior management. They considered senior management to be open and approachable.

The provider received updates on national guidance relating to employment law, human resources and health and safety via an online subscription.

The provider had a whistle blowing policy. We were assured by our discussions with staff that they were aware of the policy and understood it.

Commitment to quality improvement and innovation

Holgate House used informal approaches to consider improvements. Feedback and suggestions from staff and clients were considered at weekly house meetings and monthly management meetings.

Outstanding practice and areas for improvement

Outstanding practice

Clients received excellent support to develop sustainable recovery capital. Staff were committed and engaged. They valued and respected clients' social and emotional needs highly. They took a holistic approach, working collaboratively with other community services and providing good support for clients to engage with other recovery communities.

Clients told us that staff helped them to fully explore the reasons behind their substance misuse and develop coping strategies. They helped clients to reflect, looking back at what had happened and what they had learnt.

Staff supported clients to make links with other organisations and encouraged them to develop their social support, including mutual aid. They helped clients build the life skills they needed to help them function and maintain their independence when they returned to the community.