Lighthouse

Quality Report

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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.

Summary of findings

Overall summary

The provider has made progress since the previous inspection and we recommend the service be removed from special measures.

We rated the Lighthouse as requires improvement because:

- The service had not assessed and mitigated environmental risk to clients. Following the change in medicine administration the manager had stopped clients progressing with the self administration process. Support plans, risk assessments and risk management plans were not reviewed following incidents.
- Staff did not follow the Mental Capacity Act. Client records were not complete, current and contemporaneous. Group therapy activities in relation to addiction and lifestyle were not taking place as marketed. Lighthouse did not consider blood borne viruses of clients and staff did not have training in this area.
- Although the governance procedures and oversight had progressed, there were areas that the manager did not have oversight of. There was no risk register in place. Staff were not receiving supervision in line with the providers policy. Clients were not involved in the running and development of the service.

However:

- We observed, and clients told us, that staff at all levels were respectful approachable and responsive to the clients' needs. Clients were involved in the local community. Residents meetings took place and change happened following these meetings.
- Lighthouse was accessible for people with mobility needs and had a variety of rooms and facilities to pursue activities or have access to a quiet environment, dependant on client preference. Clients spoke positively about the new chef; saying that they provided tasty and varied food. Clients knew how to complain, information was displayed, and the manager was following the complaints policy.

Summary of findings

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Lighthouse

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Summary of this inspection

Background to Lighthouse

Lighthouse provides accommodation and support to adults with a substance misuse need and associated needs, including mental health problems. The service provides accommodation with support from staff who do not have a medical or nursing qualification. Although staff provide a range of activities and interventions aimed at helping clients live a drug-free life and to acquire skills to live more independently, specialist mental healthcare is provided by external providers. Lighthouse is funded from the mental health teams and clinical commissioning groups not substance misuse commissioning. Lighthouse is part of a group of services managed by Bloomcare.

Lighthouse is based in a residential area of Manchester with 44 bedrooms over two floors. At the time of the inspection there were 20 clients living there.

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

Since the last inspection, a new manager joined the service in February 2019. The manager had started the process of applying to be the registered manager with CQC. Following a review of the service by the provider and discussions with commissioners, the directors have decided to apply to be registered for the regulated activity; accommodation for persons who require nursing or personal care. As they believe the regulated activity better reflects the service they are providing, and one commissioners want to purchase.

This is the third inspection of Lighthouse. Lighthouse was last inspected in November 2018. Following that inspection, CQC rated Lighthouse as Inadequate overall and placed the service in special measures. We rated safe and well led as inadequate, effective and responsive as requires improvement and caring as good. We issued two warning notices for Regulations 12 Safe Care and Treatment and 17 Good Governance and a requirement notice for Regulation 18 Staffing.

At this inspection significant progress had been made. All repairs had been completed, building checks took place at the required frequency. Food hygiene checks were taking place. Risk assessments had been introduced to assess the appropriateness and safety of females being in a bedroom near males. Staff had received training in drug misuse and how to administer naloxone. There was a staffing matrix in place and mangers used it to calculate staffing levels.

There was a system of clients signing in and out of the building. Risk management plans were in place in all files we reviewed. Physical identity forms were completed with photographs of clients however the information about distinguishing details could be more detailed. The duty of candour policy reflected the regulation. Staff adhered to the policy for complaints; there was a file in place that included letters to complainants. There were signs up to advise CCTV was in use. All policies were Bloomcare and recently reviewed. Resident meetings took place, chaired by the manager and actions were completed and clients fed back on change being made. The training matrix was accessible locally at Lighthouse. The inspection team felt the service had met the two warning notices and requirement notice and recommend the service be removed from special measures.

Our inspection team

The team that inspected the service comprised one CQC inspector, one CQC assistant inspector and a specialist advisor with a variety of experience of working in substance misuse services.

Summary of this inspection

Why we carried out this inspection

We inspected this service to review the progress of the service, as at the last inspection in November 2018 we placed the service in special measures and rated it inadequate.

How we carried out this inspection

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

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

This was an unannounced inspection. Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- toured Lighthouse and looked at the quality of the environment and observed how staff were caring for clients;
- spoke with ten clients who were using the service;
- spoke with five project workers;
- spoke with the manager, deputy manager and the development manager;
- spoke with three care co-ordinators and received written feedback from two commissioners;
- attended and observed a hand-over meeting, residents meeting and a client morning meeting;
- looked at six 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 service say

Clients we talked with spoke positively about the new chef and the standard of the food provided. Clients told us the environment was supportive and enabled them to progress with their recovery, staff supported them with discharge planning and aims for the future.

Clients told us that staff were respectful, approachable and supported them with a variety of needs including health appointments. Staff were always available if you needed to talk to someone. Clients enjoyed the social days out and trips available.

Clients told us their suggestions and ideas had been acted upon, particularly since the new manager joined the service.

Clients talked of their frustration and temptation of being around other clients who were using substances. However, during the inspection, we concluded that managers were addressing this. They had issued notices to terminate placements.

Clients told us the change in medicine administration takes longer than the previous blister pack arrangements. Clients that were progressing towards self administration have stopped during this change and felt their independence had been reduced. We discussed this with the manager who told us they would be reviewing the self administration of medicines by clients.

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?

Requires improvement

We rated safe as requires improvement because:

- The service had not taken a number of basic steps to ensure that clients were kept safe. The personal identity forms did not include the level of detail to accurately identify clients, client records were not current, and staff did not review risk assessments routinely following incidents.
- Managers had not assessed the environment to include risk of being a mixed gender environment with shared bathroom facilities.
- Managers did not assess the environment for potential ligature points and advise staff of how to mitigate these. Ligature cutters were purchased on the second day of inspection; however, staff were not trained in how to use the ligature cutters.
- Training levels for Naloxone (an emergency medicine to reverse the effects of an opiate overdose) was at 48% compliance and staff did not receive training in blood borne viruses.

However:

- Risk management plans were in place for clients in the records reviewed.
- There was a system in place for clients to sign in and out of the building and staff knew who was in the building.
- Staff had received training in drug awareness and overdose.
- Individual risk assessments were completed for female clients in relation to them having to pass male clients' bedrooms to access the bathroom. A female bedroom corridor had been created and access to a female only lounge.
- Staff had completed repairs to the environment and undertook health and safety audits and building and kitchen checks at the prescribed frequency.
- Managers had introduced a staffing dependency tool that they used to calculate the number of staff required on each shift.
- Managers ensured policies that staff followed were the providers. The duty of candour policy had been reviewed to meet the regulation.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of this inspection

- Staff did not follow the Mental Capacity Act in relation to assessing a client's capacity in relation to a specific decision where staff had concerns about that client's decision making and understanding.
- One of the six records reviewed did not have an initial assessment in their record. Support plans were not reviewed following incidents.
- Group therapy activities in relation to addiction and lifestyle were not taking place as marketed.
- Blood borne virus testing was not routinely offered. Records did not confirm clients' needs in this area and staff were not familiar with the needs of clients in relation to this.
- Staff were not receiving supervision in line with the frequency expected.

However:

- All records reviewed had support plans in place, with new style care plans being created by their key workers.
- The healthy lifestyles group took place and included supporting clients to access exercise opportunities in the local community.
- Staff received a comprehensive induction to the service.
- Staff received training relevant to their role including drug awareness and Naloxone administration.

Are services caring?

Good

We rated caring as good because:

- We observed, and clients told us, that staff were respectful, approachable and responsive to their needs.
- Records confirmed, and clients told us, that staff supported them to access other services relevant to their needs included health, housing and drug and alcohol services.
- Clients told us the environment was supportive and enabled them to progress with their recovery.
- Residents meetings took place. Change was evident, and clients praised the progress that had been made since the new manager starting.
- Key workers were in place to provide consistency to clients.

However:

- The handbook that staff gave to clients on admission was out of date.
- Clients were not involved in the running of the service, for example training or recruiting staff.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

Summary of this inspection

- The service had not introduced discharge planning for clients. We asked the service to address this at the last inspection. None of the six records that we reviewed contained a discharge plan.
- The referral policy to Lighthouse did not reflect the referral process as it included another provider's website.

However:

- There was capacity within the service and referrals could be responded to promptly.
- Staff developed support and risk management plans that included how they could help clients to access local community activities and resources. Staff supported clients to access other services including physical health specialists, community drug services and community mental health services.
- Staff encouraged and facilitated access to the local community and activities included swimming, courses at the local community centre and walks. The activity coordinator supported clients on a one to one basis to develop their skills and participation in the local community including photography and painting.
- Lighthouse was accessible for people with mobility needs and had a variety of rooms and facilities to pursue activities or have access to a quiet environment, dependant on client preference.
- Clients spoke positively about the new chef. They told us that the chef provided tasty varied food. Clients had access to a choice of good quality food including access to special dietary requirements.
- Clients knew how to complain, information was displayed, and the manager was following the complaints policy.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- Managers did not ensure there was an accurate, complete and contemporaneous record for each client.
- Staff did not receive supervision in line with the provider's policy.
- The service was not implementing the Mental Capacity Act. Staff had not completed mental capacity assessments for clients where there was a concern regarding their decision making.
- Managers did not assess the environmental risks to clients in relation to ligature points and did not provide training to staff in how to use ligature cutters.

Summary of this inspection

- In its marketing material, the service claimed to provide a range of therapies for addictive behaviours. In practice, it did not provide a number of these therapies.
- There was no risk register available at the time of the inspection.
- Lighthouse did not engage clients, families/carers in staff in the planning, development and delivery of the service.
- Lighthouse was not involved in any peer review or research.

However:

- A new manager had joined the service in February 2019. Feedback from staff and clients was they were approachable, a strong leader and had implemented change.
- Staff morale was high. Staff felt energised and had areas to focus on including the introduction of new documentation for clients and the development and facilitation of therapeutic groups.
- Progress had been made to the governance of the organisation. The manager had introduced files for complaints, incidents and safeguarding. There were logs for each and the progress with each incident could be easily accessed. Audits and checks were taking place at the correct frequency.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff accessed e-Learning training in relation to the Mental Capacity Act of Deprivation of Liberty Safeguards with 100% compliance.

Staff we spoke with understood the concept of assuming that clients had the mental capacity to make decisions about their care and treatment and that people who had mental capacity could make unwise decisions. However, staff did not understand that they could complete capacity assessments, they thought it had to be completed by the client's care coordinator.

Records reviewed showed evidence of clients giving their consent to treatment and sharing of information.

There were three examples where there were reasons to doubt a client's capacity, in relation to living arrangements and physical health. Staff had not competed capacity assessments. One record had a risk report completed which stated a request for a capacity assessment was required in relation to client's eating and smoking and the impact on physical health conditions. However, this capacity assessment had not been completed. When discussed with the manager they were aware of this and had planned to complete the required capacity assessments.

Requires improvement

Substance misuse services

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

Are substance misuse services safe?

Requires improvement

Safe and clean environment

Our tour of the environment confirmed, and clients told us that Lighthouse was clean and well maintained. Cleaning records, kitchen checks and building checks were completed and up to date.

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.

Following our last inspection, repairs had been completed, sanitary bins were in the toilets and a clinical waste contract arrangement was in place.

Records confirmed that equipment was serviced within the allocated frequency. The clinic room was organised, and medicines were stored safely. However, we found the sharps bin in use had not been labelled with the start date of using the bin.

Safety of the facility layout

Closed circuit television was in place in communal areas. Signs were displayed to inform clients, staff and visitors of this.

At the last inspection, the service had not assessed or mitigated the risks of a mixed gender environment. Clients shared bathrooms, this meant some clients passing bedrooms of the opposite gender to access the bathroom. Female clients now had risk assessments completed to assess the appropriateness of them sharing a corridor with members of the opposite gender. A female only area had been created with four bedrooms and a female only lounge. However, there were still males and females on the same corridor who would have to pass each other's rooms to access the bathroom. Although individual risk assessments were in place for females, the environment had not been assessed to consider the risks posed to clients and considerations for new admissions.

Following the last inspection, clients now had to sign in and out of the building and staff answered the door to them and signed them out of the building. Care coordinators talked positively about the increase in safety of clients. Personal emergency evacuation plans were in place for clients who would not be able to leave the premises unaided in the event of a fire. The service had an up to date Fire Risk Assessment in place and the recommended actions had been completed.

All clients had mental health needs in addition to their substance misuse, some of whom were at risk of ligature or had documented thoughts of ligature. During the tour, we identified several potential ligature anchor points (places to which clients intent on self-harm might tie something to strangle themselves.) in the building. When we asked, staff told us that there was not an environmental risk assessment in place that included ligature risks. Following the inspection, the manager arranged for an environmental risk assessment to be completed. Staff confirmed there were no ligature cutters within the building. This meant staff were not aware of the ligature risks to clients and did not have the equipment to respond if a client ligatured. The

manager had purchased two pairs of ligature cutters by the second day of the inspection and following the inspection, told us that training had been arranged for staff regarding ligatures and ligature points.

Safe staffing

Since the last inspection, directors introduced a dependency tool, the manager rated each client in relation to support needs. The tool then generated the numbers of staff required on each shift. The manager used this to determine the number of staff required. This meant managers could determine how many staff were required to safely support clients.

Staffing levels and mix

We reviewed the January 2019 rotas and found the staffing numbers matched the recommended levels. Lighthouse used suitably qualified bank staff in addition to permanent staff. Rotas confirmed they were regular staff.

Clients told us, and we observed there was enough staff available to meet the identified needs of clients.

Mandatory training

Mandatory training for staff was safeguarding, health and safety, manual handling, fire safety and safe administration of medicines. All with 100% compliance.

Other training provided which staff accessed included infection control, Mental Capacity Act and Deprivation of Liberty Safeguards, diversity and equality, alcohol misuse, drug misuse, effective behaviour management, first aid at work, control of substances harmful to health, food hygiene, safe administration of medicines and nutrition and diet all with 100% compliance.

At the last inspection we identified a client prescribed Naloxone, an emergency medicine to reverse the side effects of an opiate overdose. Only one member of staff had received training in how to administer the medicine. At this inspection, records confirmed further staff had been trained in the administration of naloxone with 48% compliance. However, new staff have joined Lighthouse since the training was provided.

Staff did not receive training in blood borne viruses and were unclear about their role in supporting clients with these needs in relation to monitoring and reviews.

Assessing and managing risk to clients and staff

Assessment of client risk

We reviewed six care records and found all had a comprehensive risk assessment in place. At the last inspection, records did not include risk management plans. At this inspection, all records included risk management plans which had actions to the client, Lighthouse staff and noted involvement with other organisations and their role, e.g. the mental health team and local community drug service.

Staff told us, and care coordinators confirmed that Lighthouse staff were proactive at raising concerns with care coordinators when a client was deteriorating.

Management of client risk

Three records included evidence of harm reduction advice shared with clients. Records confirmed staff contacted pharmacists for advice following clients using illicit substances and whether it was safe for them to take their prescribed medicines.

Clients told us, and records confirmed staff supported clients to access physical health services including the GP, diabetes and weight management services.

When a client's physical health deteriorated, staff contacted physical health services.

We observed a handover and found it was effective. Staff handed over regarding each client including risks posed and incidents that had occurred.

Use of restrictive interventions

Lighthouse service rules were in place to explain the expectations to clients including no alcohol or drugs on the premises, no entering other client's bedrooms or borrowing from or lending to each other. The service introduced these to safeguard vulnerable clients who would give items away to others or be vulnerable to other clients. These were proportionate to the service provided and the vulnerability of some clients. Searching took place on an individually assessed basis and were appropriate to the service.

Safeguarding

Staff understood their role in relation to safeguarding. Staff implemented statutory guidance around vulnerable adult

and children and young people safeguarding and staff were aware of where and how to refer on as necessary. Records noted, and notifications received by CQC confirmed safeguarding alerts were being made to the local authority.

The manager had introduced a safeguarding log which captured the incident, action taken and whether a notification to CQC needed to be submitted, the manager had oversight of the safeguarding incidents.

Care coordinators told us, and records confirmed that staff worked effectively within teams, across services and with other agencies to promote safety and reduce risks and vulnerabilities to clients.

Staff had up to date safeguarding training with 100% compliance.

Staff access to essential information

We reviewed six records. All records were paper based and stored in a locked cupboard in the staff office.

All records had risk management plans in place and physical identity forms with photographs on. These were not in place at the last inspection but the level of detail in the description of clients' distinguishing issues on the physical identity form were insufficiently detailed in the records we reviewed. For example, a form stated that a client had self-harm scars but did not explain where they were. Another stated that the client had a tattoo on their arm but not on which arm or what the tattoo was of.

Records were not contemporaneous and up to date. Three health action plans were not fully completed or dated. One support plan had two sections of the new style support plan completed. Another support plan had not been reviewed for over five months and not reviewed following an incident nor the risk assessment updated. The key worker responsibility policy dated January 2019 states key workers should review their client's care plans monthly. Staff were not following this policy. This meant records may not reflect client's current needs and circumstances.

One of the six records reviewed had no assessment in the file, staff confirmed there was not one available. The client's risk assessment and support plan had not been updated following an incident.

Two other client records had not had the support plan reviewed for seven months.

This meant staff did not have access to current and complete information regarding the clients they were caring for.

Medicines management

We reviewed the premises and found medicines were stored safely in a locked room. Staff completed all necessary checks including of the room temperature and fridges which were within range. In general, staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal) and did it in line with national guidance.

Since the last inspection, the service had stopped using blister packs for medicines prepared by the pharmacist. Instead, staff administered medicines from the original packaging. Staff and clients were still adjusting to this. There had been recent incidents relating to mis-administration of medicine. The manager offered additional support and training to staff following incidents to ensure they were competent to continue with this role.

Lighthouse had policies, procedures and training related to medication and medicines management. All policies were now one brand, Bloomcare as at the last inspection there were three different brands of policies in circulation.

Following the last inspection staff had received training in how to administer Naloxone, an emergency medicine for people who have taken an opiate overdose.

Staff were following the policy in relation to the administration of controlled drugs, with two staff signing and witnessing the administration.

Clients told us, and staff confirmed that following the change in medicine administration, those who were previously progressing to self administration had been stopped during the transition. The manager told us that they would be reviewing this situation to enable clients to develop their skills in self administration. There were three clients fully self-administering and this continued. Clients had lockable space in their rooms where medicines could be stored.

Reporting incidents and learning from when things go wrong

Requires improvement

Substance misuse services

Lighthouse staff knew what incidents to report and how to report. Staff were now following the Bloomcare incident reporting policy. Once the staff member had completed the report, the manager reviewed this, identified any actions and identified any learning to be shared.

We reviewed the monthly review of incidents and found the manager had developed a system to identify the incident, who the client was, if a CQC notification was required and any safeguarding referral. The manager hoped this information over time would show themes and trends in relation to incidents. We reviewed the team meetings minutes and found the learning from incidents was shared at team meetings.

Records showed, and clients told us that a couple of clients had generated several incidents and at times they did not feel safe within the service and illicit substances had been used. On review of the incidents, records showed the manager had acted on these concerns by meeting with the clients involved in the incidents, explaining the situation and the expectations regarding their behaviour and had issued a final written warning. During the inspection a further incident had occurred and the client's placements at Lighthouse were terminated. Staff involved the clients care coordinators in this decision and process.

We reviewed the duty of candour policy dated January 2019, and found it reflected the regulation including keeping a written record of action taken. Staff understood the duty of candour. There had not been any incidents meetings the threshold for the duty of candour since the last inspection.

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

Requires improvement

We reviewed six care records.

Assessment of needs and planning of care

Of the six records reviewed, one did not have an assessment in their file. Staff told us that this may have been because the client had been at Lighthouse on a previous and recent occasion and staff might have had considered that the previous assessment would still apply. However, the previous assessment was not in the file.

The service was transitioning from bespoke support plans for Lighthouse to the organisational care plans of Bloomcare. The manager told us this was to align with other services and for consistency. We reviewed one record which contained the new care plans and documentation. New care plans included personal care, privacy and dignity, sleeping, breathing, mental health and nutrition. This was also in preparation for the application to change the registration of regulated activity. The manager advised an additional care plan had to be introduced for addictive behaviours to reflect the needs of clients at Lighthouse.

All records reviewed had support plans in place. However, support plans had not been recently reviewed and staff were in the process of creating new style care plans with clients. These were in progress during the inspection.

Records showed assessments were holistic, personalised and include physical health care check. However, blood borne virus testing was not routinely offered. Records did not confirm client's needs in this area and staff were not familiar with the needs of clients in relation to this.

We found that all records included a risk management plan tailored to the client's individual needs. However, staff had not reviewed the support plans and risk assessments following incidents. This meant that records were not current and contemporaneous, staff would not have access to the most recent information regarding clients.

Best practice in treatment and care

At the last inspection, group activities in relation to addiction, behaviour and mental health were marketed as being offered weekly. In fact, only the session regarding mental health was taking place weekly.

At this inspection staff told us that there was a plan in place to redevelop the groups. Future sessions would include life skills, addiction and healthy lifestyles groups. The first group of the revised focus was due week commencing 13 May 2019 of life skills and addiction group. However, the healthy lifestyles group took place regularly. Following the inspection, the manager told us that three sessions were taking place daily on life skills, healthy living and addiction and recovery with each session having a feedback sheet completed by clients to allow for review of the sessions.

Substance misuse services

The healthy lifestyles group included clients having an induction to the gym at Lighthouse, wellbeing survey, exploring healthy foods and activities within the local community including swimming.

Monitoring and comparing treatment outcomes

Following discussion with commissioners, Lighthouse is funded from the mental health teams and clinical commissioning groups not substance misuse commissioning. This meant Lighthouse could not participate in the national drug treatment monitoring reporting. Lighthouse and commissioners agreed the future focus of the service would be for people with mental health needs and associated needs including substance misuse. The manager and directors would explore the registration changes when the manager applied for registration.

Skilled staff to deliver care

Staff that worked at Lighthouse included a manager, deputy manager, project workers, support workers, chef, domestic staff and an administrator. Records confirmed staff received a comprehensive induction to the service.

Lighthouse provided and ensured all staff have completed mandatory training with 100% compliance. Other training provided which staff accessed included infection control, Mental Capacity Act and Deprivation of Liberty Safeguards, diversity and equality, alcohol misuse, effective behaviour management, first aid at work, control of substances harmful to health, food hygiene, safe administration of medicines and nutrition and diet all with 100% compliance.

At the last inspection, we identified staff had not received training in drug misuse and overdose awareness and how to administer the emergency medicine Naloxone. At this inspection, staff had completed drug misuse training with 100% compliance and Naloxone training with 48% compliance.

During this inspection, the manager identified that staff required training in how to respond if a client ligatured and how to use ligature cutters, following the inspection the manager confirmed this had been booked for 12 June 2019.

We reviewed seven staff files and found robust recruitment processes were followed including application forms, interview notes, proof of identity and references and a completed induction. However, we found that contracts were in place and signed by the employee but not the employer. Risk assessments were completed for staff with previous convictions.

The provider's expectation of the frequency for supervision was three monthly. We reviewed seven staff supervision records and found that two staff had received supervision within the expected frequency and five staff had not received supervision within the expected frequency. This meant staff did not receive the one to one time with their manager for support and development. Of the four staff requiring an appraisal, three of them had had an annual appraisal.

Records confirmed poor staff performance was addressed promptly in supervision with their manager.

Multi-disciplinary and inter-agency team work

The staff team at Lighthouse consisted of a manager, deputy manager, recovery workers, support workers, a chef an administrator and domestic staff.

Care coordinators told us, and records confirmed there was multidisciplinary input into client's care from, for example, community mental health teams (CMHT), GPs, district nurses, community drug services and criminal justice services

Care coordinators were clearly identified within records and attended reviews at Lighthouse.

Team meetings took place monthly, at two different times to try to include staff working on day and night shifts. Handovers took place between day and night shift and included a summary of each client.

Support plans include clear care pathways to other supporting services. Works with health, social care and other agencies to plan integrated and coordinated pathways of care to meet the needs of different groups. Risk management plans had actions to clients, Lighthouse staff and other providers including drug teams, and mental health teams.

Good practice in applying the Mental Capacity Act

There was a Mental Capacity Act policy dated January 2019. Staff accessed eLearning training in relation to the Mental Capacity Act of Deprivation of Liberty Safeguards with 100% compliance.

Requires improvement

Substance misuse services

Staff we spoke with understood the concept of assuming capacity and that people can make unwise decisions. However, staff did not understand that they could complete capacity assessments, they thought it had to be completed by the client's care coordinator.

Records reviewed showed evidence of clients giving their consent to treatment and sharing of information.

There were three examples where there were reasons to doubt a client's capacity, in relation to living arrangements and physical health. Staff had not competed capacity assessments. One record had a risk report completed which stated a request for a capacity assessment was required in relation to a client's eating and smoking and the impact on physical health conditions. However, this capacity assessment had not been completed. This meant Lighthouse were not following the Mental Capacity Act. When discussed with the manager they were aware of this and had planned to complete the required capacity assessments.

There were no examples of best interest decisions taking place.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We observed, and clients told us staff were respectful, approachable and responsive to their needs. There was staff available if clients needed to talk to someone.

Staff demonstrated a compassionate understanding of the impact peoples' care can have on their emotional and social wellbeing. Staff responding to clients approaching them for support by spending time with them, listening to clients, explaining the situation and ensuring clients understood the information.

Lighthouse had staff who showed an understanding of peoples' needs regarding their gender, ethnicity, religion, sexual orientation, age and disability and how these might relate to their substance misuse.

Records confirmed, and clients told us that staff supported them to access other services relevant to their needs included health, housing and drug and alcohol services.

Staff maintained the confidentiality of clients by ensuring conversations regarding clients took place in the office, where clients could not overhear. Clients signed consents regarding professionals' access to their information.

Clients told us the environment was supportive and enabled them to progress with their recovery, staff supported them with discharge planning and aims for the future.

Involvement in care

Involvement of clients

Clients had keyworkers who were their named staff for completion of documentation and facilitating keywork sessions. Support plans and risk assessments and management plans included goals for clients to work towards and the support offered by Lighthouse staff and staff from other organisations to achieve this.

Access to advocacy was available to clients and clients were aware of this.

Clients were given a handbook when they arrived at Lighthouse. This included support offered by Lighthouse staff and expectations of clients. However, this handbook was out of date following changes in staffing and documentation.

Daily morning meetings took place, we observed staff and clients discussing plans for the day expectations of clients in relation to the cleanliness of Lighthouse, future plans for activities in the local community and support required.

Monthly residents' meetings took place, we observed the manager chairing the meeting. Changes had taken place following client feedback including to the availability of coffee and sugar. The manager suggested the possibility of a point system to encourage clients to be more involved in household tasks around the building resulting in vouchers for clients. The manager provider updates to clients in relation to the revised group therapy work, changes in documentation and ideas of capturing progress including a you said we did board and an appreciation board. Clients told us their suggestions and ideas had been acted upon, particularly since the new manager joined the service.

Requires improvement

Substance misuse services

Feedback questionnaires had been circulated to staff and clients. There had been one completed client feedback form which suggested staff be allocated to facilitating activities at a weekend and that there would be more availability of vegetarian food choices.

Involvement of families and carers

Families visited clients within the service, records included risk assessments for when visiting families if there were concerns regarding the relationships.

No carer and family feedback events, meetings or surveys took place.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access, waiting times and discharge

Lighthouse had a referral policy however this did not fully reflect the service, it was dated for review July 2019 and included reference to applying via another providers website which Lighthouse is not part of. The policy did not include an admission criteria.

The policy advised the manager or deputy manager would contact the referrer within 24 hours of receiving the referral. The service did not accept emergency referrals.

There was capacity within the service and referrals could be responded to promptly.

Discharge and transfers of care

Support and risk management plans reflect the diverse/ complex needs of the person including clear care pathways to other supporting services e.g. community drug services, housing or Community Mental Health services.

Of the six records reviewed, there were no discharge plans within the records. This meant clients were not supported to make plans for the future, with identified goals and aims to progress to. For one client there had been placement review meetings which resulted in a final warning letter which included the expectation of the client and if breached they would leave the service and the care coordinator would have to find alternative accommodation. The manager showed us a draft discharge plan that they proposed introducing which included symbols and covered topics of employment, finances, security, housing and self care.

Staff supported clients to access other services including physical health specialists, community drug services and community mental health services, clients were encouraged to attend independently when their skills allowed.

Facilities that promote comfort, dignity and privacy

Lighthouse was accessible for people with mobility needs, the service was over two floors with flat access and a lift to the upper floor.

There were several communal areas for clients to spend time, with availability to drinks and snacks. Activities available included computer suite, a gym, pool tables and table tennis. We saw clients regularly participating in these activities. Quieter spaces were also available with quiet lounges if clients preferred this. Clients had open access to an outside space that was clean and well maintained.

Clients had their own bedrooms which they personalised. The majority of which were not en-suite facilities. Since the last inspection there was a female only corridor with four bedrooms and a review of allocation of bedrooms had taken place. There was a female only lounge available for clients too.

There were enough empty bedrooms to allow for clients moving bedrooms, to accommodate repairs and following incidents.

Clients spoke positive about the new chef. Stating they provided tasty varied food. Clients had access to a choice of good quality food including access to special dietary requirements for example kosher or halal meat, vegan and diabetic diets.

A breakfast club had recently been established, clients were involved in making breakfast with a variety of food options, clients spoke positively about this and suggested different food choices.

Clients' engagement with the wider community

Staff encouraged and facilitated access to the local community and activities included swimming, courses at the local community centre and walks.

Requires improvement

Substance misuse services

There was an activity coordinator who supported clients on a one to one basis to develop their skills and participation in the local community including photography, painting and culture club.

Staff supported clients to maintain contact with families and carers. Visits took place at Lighthouse. Staff supported clients to meet the expectations of children's services where the children had been removed from their care, including having contact with their children.

A connection had been made with a local church. Previously the ALPHA course, a series of sessions exploring the Christian faith had been facilitated at Lighthouse however it was hoped that future courses may take place at the local church.

Clients accessed Narcotics Anonymous and Alcoholics Anonymous in the local community, staff provided support to access this where needed.

Meeting the needs of all people who use the service

Staff demonstrated an understanding of the potential issues facing vulnerable groups e.g. LGBT, BME, older people, people experiencing domestic abuse and people with literacy difficulties and offered appropriate support.

Staff made adjustments for people in response to their needs e.g. disabled access, faith support, young visitors could access a private room for visiting.

Listening to and learning from concerns and complaints

Lighthouse had made links with the local advocacy services and had encouraged one client to seek support and guidance from an advocate.

There was a poster in reception advising clients how to complain, the process was also included in the client handbook which clients received at admission.

The complaints policy dated January 2019 advised the complaint would be acknowledged and investigated within 28 days. We reviewed the complaints file and found a log in place which captured the date complaint made, nature of complaint, date acknowledgement letter sent, actions taken, outcome and date closed.

Since the manager started, there had been three complaints. The manager followed the policy and stored copies of the correspondence sent to the complainant within the file. There was a section within the file for low level concerns, usually client on client issues, which were noted and resolved including action taken.

Of the six clients asked regarding complaints, all knew how to complain and understood the process.

Learning and themes regarding complaints were discussed at team meetings.

Are substance misuse services well-led?

Requires improvement

Leadership

Since the last inspection, a new manager joined the service in February 2019. Feedback from staff and clients was they were approachable, a strong leader and had implemented change.

The service was going through a period of transition as directors and commissioners had agreed the service should focus on caring for people with mental health needs who may also have substance misuse needs. In preparation for applying to be the registered manager and applying to change the regulated activity provided, the provider policies had been introduced and client's records were being transferred to the provider documentation to align with other services provided.

The development manager attended the service to facilitate training and was present during the managers induction to the role. The director and Nominated Individual visited the service and was present at the recent engagement meeting.

The chief executive and the development manager had co facilitated the Alpha course.

We observed managers being approachable, with clients coming up to them to chat and managers giving time to clients to listen.

Vision and strategy

The aim and values of Lighthouse were "to offer practical and goal focused support to clients. The support is holistic and includes close work with other agencies to ensure clients' needs and personal goals are met."

Requires improvement

Substance misuse services

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.

We reviewed seven staff files and found all included a job description and other recruitment requirements. However, we found that contracts were in place and signed by the employee but not the employer.

Minutes confirmed discussions took place in team meetings regarding the governance of the service.

Culture

Feedback questionnaires from staff regarding the new manager stated they were empowering, bringing positive change to the service, motivational and show appreciation. An area for improvement was for staff to receive more supervision.

The manager described having a mentor from another manager within the organisation which they valued.

Staff told us they felt valued and listened to and there was more structure within the service.

Of the four staff requiring an appraisal, three of them had had an annual appraisal. Appraisals included conversations about career development.

Staff morale was high. Staff felt energised and had areas to focus on including the introduction of new documentation for clients and the development and facilitation of therapeutic groups.

Staff told us, the manager and provider were supportive of their specific needs; members of staff who were fasting advised the service was supportive of the activities they pursued during fasting due to decreased energy levels and advised the service provided space to pray within the building.

The staff team worked well together and where concerns were raised, staff records confirmed managers addressed this.

Governance

Since the last inspection, progress had been made to the governance of the organisation. The manager had introduced files for complaints, incidents and safeguarding. There were logs for each and the progress with each incident could be easily accessed.

Policies were all in date and one provider; Bloomcare. The duty of candour policy was compliant with the regulation. Staff were following policies in relation to CCTV and complaints.

Managers could access a training matrix at local level with the training attendance of staff, this was updated locally.

The manager was completing daily walkarounds, on an iPad which fed into a monitoring system at provider level. Topics included medicine, environment, wellbeing of residents and training. The directors had access to this and could escalate issues if needed. The information submitted via the audits would create a risk register for Lighthouse from the intelligence collated. However, this system had not been in use long enough to generate a risk register. Daily medicine audits also took place.

Local governance arrangements supported the delivery of good quality care. Feedback was sought from clients and staff in meetings and in feedback questionnaires.

Minutes confirmed learning from incidents and complaints was discussed at team meetings.

The manager submitted statutory notifications to CQC as required, their log of incidents and safeguarding provided oversight of this.

Although progress had been made in relation to the governance of the service, there were still areas without management oversight.

There was no oversight in relation to staff receiving regular supervision. The manager told us this was an area to improve on. We reviewed seven staff supervision records and found that two staff had received supervision within the expected frequency and five staff had not received supervision within the expected frequency.

The manager identified capacity assessments had not been completed for clients where there was a concern regarding their decision making. Records were not contemporaneous, current or reviewed following incidents. This meant records did not provide staff with relevant changes and updates regarding clients.

Requires improvement

Substance misuse services

Lighthouse did not assess the environmental risks to clients in relation to ligature points and did not provide training in how to use ligature cutters.

Assessments, risk assessments and support plans were not reviewed following incidents and policies did not include the review of these documents following incidents.

Lighthouse were not providing recovery sessions in relation to addictive behaviour as marketed in the handbook. This was being developed during the inspection and due to commence the week after the inspection. Following the inspection, the manager confirmed that the three sessions were taking place.

Management of risk, issues and performance

There was no risk register available at the inspection, directors decided the previous document in place at the last inspection was not fit for purpose. The manager had started to complete the daily audits and reporting of incidents and complaints on the electronic system which would form the risk register when there was enough data as the manager started this in March 2019. This meant staff and managers were not aware of the risks to the service to be able to effectively mitigate them.

The human resources department monitored staff sickness and absence rates.

The provider supported the improvements within the service in relation to staffing, facilities and activities to improve the quality of the service.

Information management

The maintenance team completed the environmental checks and the chef completed the food safety checks, the manager completed the daily audits as part of their role. This ensured the people with the right skills completed the checks and audits.

Staff used an internet based drive to store documents and these could be shared with colleagues as appropriate. A phone application was used for staff to log maintenance repairs and the director responsible for buildings could access this to authorise jobs.

Staff signed in and out of the building electronically and this could be accessed by a phone application.

Client records were in paper format and stored securely. However, they were difficult to navigate as historical documents were still within the files. This made it difficult to find the desired information efficiently.

There was no report or centralised system that managers could access to show the performance of the service. Information would have to be gathered from a variety of sources.

Engagement

Staff and clients had access to up to date information regarding the provider via meetings. The website was up to date with the last CQC report and rating and the details of the new manager.

Staff and clients had the opportunity to give feedback via questionnaires, residential meetings, daily morning meetings, team meetings and supervision. The manager also offered an open door policy and staff and clients told us they were approachable.

Directors and the development manager visited the service and were happy to receive feedback from clients and staff. We observed clients approaching them and senior managers listening to clients.

Externally the manager had registered to be part of the care home forum and had identified training opportunities for staff via the local authority.

Lighthouse did not engage clients, families/carers in staff in the planning, development and delivery of the service. They were not involved in training or recruitment of staff. This meant the knowledge and experience of clients was not included in the development of the service and the staff team to ensure they understood the needs of clients and could meet them effectively.

Learning, continuous improvement and innovation

Following the last inspection, the local commissioner assigned a performance and quality improvement officer to support the manager in developing the service. The service welcomed this support.

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

Lighthouse was not involved in any peer review or research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the environment is assessed for potential ligature points and mitigate these. Staff must receive training in how to use the ligature cutters.
- The provider must develop and provide the recovery groups as marketed.
- The provider must ensure records are complete, current and contemporaneous, include assessments and are reviewed following incidents.
- The provider must ensure they follow the Mental Capacity Act 2005 and conduct capacity assessments where there are concerns for a person's understanding and decision making ability and must make decisions in client's best interests.
- The provider must ensure that discharge planning is captured within client records.

Action the provider SHOULD take to improve

- The provider should review the arrangements for clients being involved in their medicine administration.
- The provider should ensure that sharps bins are correctly labelled with the start date.
- The provider should ensure that the level of detail in personal identity forms are at a level to accurately identify clients.
- The provider should ensure that the environment is assessed to include risk of being a mixed gender environment with shared bathroom facilities.
- The provider should ensure refresher training is available for naloxone and consider accessing training in blood borne viruses to ensure staff are aware of specific needs of clients and how to safely respond to their needs.
- The provider should ensure that staff receive supervision in line with the supervision policy and guidance.
- The provider should review the client handbook to ensure current information is included.
- The provider should review the referral policy to ensure it reflects Lighthouse and the admission criteria.
- The provider should create a risk register for Lighthouse.
- The provider should review how clients are involved in the running and development of the service.

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 9 HSCA (RA) Regulations 2014 Person-centred care Lighthouse were not providing recovery sessions in relation to addictive behaviour as marketed in the handbook. Records did not include discharge plans for clients and there was no evidence of this being discussed with clients. This is a breach of Regulation 9 Person centred Care. 9(1) (3) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not assess the capacity of clients where they were concerned about their understanding and decision making. This is a breach of Regulation 11 Consent. 11 (3)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Lighthouse did not assess the environmental risks to clients in relation to ligature points and did not have ligature cutters.

This is a breach of Regulation 12 Safe Care and Treatment. 12 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records were not current and contemporaneous. This is a breach of Regulation 17 Good Governance. 17 (1) (2) (c)