Addiction Dependency Solutions (ADS) Bridge House

Quality Report

St Lukes Place
Preston
PR1 5DE
Tel:01772 797654
Website:www.adsolutions.org.uk

Date of inspection visit: 5th-6th April 2016
Date of publication: 25/07/2016

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.

We found the following areas of good practice:

Safe

- Communal areas that people used were all clean, comfortable and well maintained. Bedrooms were well maintained and furniture was in a good state of repair.
- A new training matrix had been developed for staff.
- Risk assessments for all clients were completed regarding the use of cleaning products.
- The health and safety risk assessment for the building was updated on a weekly basis.
- Electrical safety testing, legionella and gas safety checks had all been completed within appropriate time frames.
- All staff had first aid training.

Summary of findings

- Clients could access a range of treatments and support and there were enough staff on duty to provide those treatments.
- Appropriate pre-employment checks had been completed for all staff.
- Care records had a comprehensive assessment, up to date care plan and risk assessment with plans in place for unexpected discharge from the service.
- Medication administration records were up to date, well organised and clearly documented which medications had been prescribed.
- Staff were offered a full debrief after incidents and we saw evidence in team meetings that lessons learned from incidents were fed back to the team.

Effective

- Care records had a personalised recovery plan in place. All clients had been given a copy of their care plan.
- Groups were well facilitated and well structured.
- Staff meetings were well attended and staff were able to discuss any issues.
- There were good links with local recovery communities.

Caring

- Staff treated clients with kindness dignity and respect.
- Clients were actively involved in their care and were able to raise any issues in community meetings.
- Carers were invited to a monthly friends and family meeting where they were encouraged to give feedback and could be supported on an individual basis.

Responsive

- All clients were given a copy of the residents handbook upon admission into the service.
- We saw holistic needs assessments that had been undertaken for all the clients' records we looked at.
- Discharge planning was documented in care plans and clients attended moving on groups
- Clients engaged in community activities to prepare them for discharge.
- There was a weekly support group for ex-clients.

Well led

- Sickness and absence rates were low at 3%.
- Staff felt confident to raise their concerns to managers.
- Morale was good and the team worked well together

However, we also found the following issues that the service provider needs to improve:

- Clients and staff used a vestibule area to smoke and this filtered into the main building potentially affecting the health of others.
- Medication checked in after delivery by the pharmacist was not itemised.
- Staff were not aware of the Duty of Candour
- Staff were not aware of best practice legislation or guidelines.
- Staff were receiving regular supervision but this was not in line with the supervision policy.
- Staff had not received Mental Capacity Act (MCA) training and were not aware of the principles of the MCA.
- Some parts of the building were not accessible to people using wheelchairs or who had other types of restricted mobility.
- Clients were not aware that forms were available if they wanted to provide written feedback to staff.
- We found that the service had not developed some policies. These included the Duty of Candour and Mental Capacity Act 2005 policies. We found that some policies were out of date or had no review date. These included the supervision policy, lone worker policy and whistleblowing policy.

Summary of findings

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Summary of this inspection

Background to Addiction Dependency Solutions (ADS) Bridge House

Bridge House is a substance misuse service provided by Addiction Dependency Services (ADS). ADS runs several drug, alcohol and prescription drug addiction services across the North and Midlands of England. Bridge House provides residential rehabilitation for 16 men and women over the age of 18, whose lives have affected by drug and alcohol misuse. Clients are admitted after having been through a community or inpatient detoxification programme. The accommodation comprises of 10 single bedrooms on the first floor and six self-contained flats on the ground floor.

The philosophy of the service is therapeutic support and abstinence. The service offers a structured therapeutic programme of activities and individual 'key worker' sessions. Bridge House encourages clients to develop links with community based services, particularly in the areas of social, education and recreational resources. This helps people to build a support network within the community in preparation for their move back to independent living.

Referrals to Bridge House are made by the prospective client or professional involved in their care. Funding for clients is met by the referring local authority and/or client contributions.

There is a registered manager and the service is registered to provide accommodation for persons who require treatment for substance misuse.

Bridge House has been registered with Care Quality Commission (CQC) since December 2010. There have been three previous inspections at Bridge House with the most recent being August 2013. They were compliant with all assessed outcomes.

Our inspection team

The team leader of the inspection was Dawn Mckenzie, CQC inspector.

The inspection team consisted of three CQC inspectors.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- Looked at the quality of the physical environment, and observed how staff were caring for clients who used the service
- Spoke with seven clients who were using the service
- Spoke with three relatives or carers

Summary of this inspection

- Spoke with the registered manager
- Spoke with two other staff members
- Attended and observed a leaving group and a cooking group
- Looked at six care records
- Looked at eight medicines records for clients who used the service
- Looked at five completed family evaluation questionnaires after the monthly family meeting
- Looked at minutes from team meetings
- Looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients said that the staff at Bridge House were extremely helpful and approachable. They were non judgemental in their approach. They said that Bridge House provided a supportive environment and had a friendly atmosphere. All of the carers we spoke to were complimentary about the service and praised the staff for all the hard work they completed with their relatives.

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:

- Communal areas that people used were clean, comfortable and well maintained.
- Bedrooms were well maintained and furniture was in a good state of repair.
- A new training matrix had been developed which outlined what mandatory each staff member required and a system for monitoring that staff were up to date with required training.
- Risk assessments for all clients were completed regarding the use of cleaning products. The health and safety risk assessment for the building was updated on a weekly basis.
- Safety testing had been completed within appropriate time frames. Gas safety checks were completed annually. Legionella checks were completed weekly.
- Mandatory training rates for staff over the past 12 months was 90%. All staff had first aid training.
- There were sufficient staff in the team to ensure that clients could access the full range of available treatments and support.
- Care records had an up to date care plan and risk assessment with plans in place for unexpected discharge from the service.
- Medication administration records were up to date, well organised and clearly documented which medications had been prescribed.
- Staff were offered a full debrief after incidents and we saw evidence in team meetings that lessons learned from incidents were fed back to the team.

However, we also found the following issues that the service provider needs to improve:

- Clients and staff used a vestibule area inside the building to smoke and this filtered into the main building potentially affecting the health of others.
- Medication items initially checked in were not specified and recorded by name. This meant that
- Staff were not aware of the duty of candour and there was no policy in place.
- Staff had not been trained in safeguarding however there was a safeguarding policy in place.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- A comprehensive assessment was completed for each client prior to admission.
- We looked at six care records. All had a recovery plan in place. All clients had been given a copy of their care plan.
- Groups were well facilitated and well structured.
- All of the staff were suitably qualified in courses such as counselling and management.
- Staff meetings were well attended and staff were able to discuss any issues.
- There were good links with local recovery communities.
- Pre-employment checks for all staff were in place and up to date.

However, we also found the following issues that the service provider needs to improve:

- Staff were not aware of best practice legislation or guidelines.
- Staff were being supervised on a bi-monthly basis and this was not in line with the supervision policy.
- There was no Mental Capacity Act training or policy for staff to refer to. Staff were not aware of the principles of the Mental Capacity Act.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff treated clients with kindness dignity and respect.
- Clients were actively involved in their care and were able to raise any issues in community meetings.
- Families were invited to a monthly friends and family meeting where they were encouraged to give feedback and could be supported on an individual basis.
- Clients had completed a feedback survey in 2015. Clients either agreed or strongly agreed that they felt safe, that it was easy for people to visit them, that the meals were of a good standard and that facilities were comfortable.

However, we also found the following issues that the service provider needs to improve:

- Clients were not aware that forms were available if they wanted to provide written feedback to staff.

Summary of this inspection

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All clients were given a copy of the residents handbook upon admission into the service.
- We saw holistic needs assessments that had been undertaken for all the clients' records we looked at.
- Discharge planning was documented in care plans and clients attended moving on groups.
- Clients engaged in community activities to prepare them for discharge.
- There was a weekly support group for ex-clients held at Bridge House which provided ongoing support and advice.

However, we also found the following issues that the service provider needs to improve:

- There was no provision for wheelchair users or those who could not use stairs to access the rehabilitation service. This was due to the layout of the building.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

- We found that the service had not developed some policies. These included the Duty of Candour and Mental Capacity Act 2005 policies.
- We found that a number of policies were out of date or had no review date. These included the supervision policy, lone worker policy and whistleblowing policy.

However, we also found areas of good practice, including:

- Sickness and absence rates were low at 3%.
- Staff felt confident to raise their concerns to managers.
- Morale was good and the team worked well together.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The clients we spoke to at Bridge House had capacity. Staff told us that all clients were presumed to have capacity upon admission into the service, however staff did not receive training on the Mental Capacity Act (MCA) (2005) and there was no MCA policy. Staff were not aware of the governing principles of the MCA or what to do if a clients' capacity was to change.

There were no clients subject to Deprivation of Liberty safeguards.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

The communal areas that clients used were clean, comfortable and well maintained. We saw that interview rooms were private. There was a main lounge where some groups took place and an art room downstairs which could also be used as a quiet space if clients wanted to talk. There was also a quiet lounge were clients could see visitors. Furniture and furnishings were in good repair and there was an on-site handyman who responded to requests for maintenance.

The bedrooms were well maintained, comfortable and furniture was in a good state of repair. There was a wash basin in each bedroom and a wardrobe, bed and drawers. Clients were complimentary about their bedrooms. Rooms were personalised and in the self-contained flats clients had brought items of their own furniture and home comforts such as coffee machines.

There was one corridor for males with a dividing door between that and the female corridor. There were separate bathrooms with bath and shower for males and females on each corridor.

Clients had responsibility for cleaning their own rooms which were checked on a weekly basis and there was a clients' rota for communal areas. There were no domestics employed by Bridge House. There was a locked cupboard where household domestic products were kept. All clients were assessed upon admission around the use of cleaning products. All products used did not contain any bleaches and records were kept of this. Control of substances hazardous to health protocols were detailed within the health and safety policy which was dated 2011 with no review date but included a statement of intent signed by the chairman of Addiction Dependency Services in 2015. We looked at the health and safety risk assessment for the building. This was updated on a weekly basis by the staff and reviewed by the service manager.

Safety testing had been completed and was up to date on the electrical items we looked at. Gas safety checks were completed annually and the current certificate was on display in the main hallway. Asbestos checks were also completed annually by the landlords of the property.

There were weekly fire safety checks which checked emergency lights, escape routes and fire door inspections. We observed the weekly fire alarm check being completed whilst we were on the premises. There had been a full fire drill completed in the last 12 months. There was a fire warden identified for each shift.

Legionella checks were completed weekly including testing of unused taps and showers.

There was a no smoking policy dated 2011and this stated that all ADS premises should be smoke free. However smokers used a vestibule area inside the building to smoke and this filtered into the main building. This had a direct impact upon the health and safety of the clients and staff, especially the managers and administrator who had offices on the ground floor.

All staff had first aid training and there was a first aider identified for each shift. In the event of a physical health or psychiatric emergency staff knew to access assistance via 999. There was a defibrillator on site and we saw in minutes of meetings that arrangements had been made for all staff to be trained in the use of this.

There were ligature points in the building and in bedrooms although a ligature risk assessment had been completed. A ligature point is a place to which patients intent on self-harm might tie something to strangle themselves. The provider told us that they did not admit people who may

be a risk to themselves. There had been no incidents of self- harm by ligature or any other means. However it was acknowledged that clients who were admitted were more complex than previously and this included those with mental health problems. If a client subsequently indicated they were a risk to themselves they would be risk assessed and referred to the GP, community mental health team or crisis services for increased input and ongoing assessment.

There was a lone worker policy. This had last been reviewed in 2007. This included a requirement to risk assess around lone working and to use the lone working log book.

Safe staffing

The service employed a full-time manager, deputy manager and three support staff. It had one administrator and one cook. Bank and agency workers who knew the service well covered when staff were on annual leave or if there was sickness. There were two volunteers and one peer mentor who assisted with groups and supported clients to go out. If extra staff were needed the manager was able to bring in staff from the wider organisation as required. All the clients we spoke to said that staff were present at all times and that activities were never cancelled because of shortages of staff.

The service was staffed 24 hours a day. There were three shift patterns during the day, 8am-4pm, 9am-5pm and 11am-7pm. From 8am-9am there were two members of staff on duty. From 9am-5pm there were four staff on duty not including volunteers or peer mentors. There was one member of staff on duty from 5pm until handover at 6.30pm. There was one member of staff on duty overnight. Lone working policy had been followed with regard to staff on duty from 5pm.There was an on-call system where another member of staff was available over the telephone or in person for support and assistance. In the event of an emergency staff were told to dial 999 before phoning the person on-call. In addition all clients had risk assessments completed prior to and throughout their admission and the service would not accept clients assessed as high risk to themselves or others.

Mandatory training rates for staff over the past 12 months were 90%. A new training matrix had been introduced for 2016 and this included first aid, safeguarding, equality and diversity, health and safety, drug and alcohol awareness, human resource systems, fire marshall, and data protection.

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

We looked at the care records of six clients. All of the records we looked at had an up to date risk assessment present that took into account issues around risk to self or others, medication, daily duties, going out and social activities. However one of the risk assessments was basic and did not go into detail about one clients risk history of harm to themselves and others. All risk assessments had been signed by both staff and clients. There was evidence of blood born virus assessments where appropriate and a full history of substance misuse including previous access to treatment facilities. There were plans in place for unexpected discharge from the service. All of the care records were individualised. Mental health assessments were incorporated into the admission assessment and a history was taken from the GP records or other appropriate sources. All records had a completed and signed confidentiality agreement within the files.

As well as individual risk assessments, group risk assessments were completed for day trips or other events out of the usual day to day running of the service. We saw a risk assessment that had been completed for a trip to the Lake District which detailed risk of substance misuse around free time, lunch time and clients evening meal.

The staff we spoke to were aware of safeguarding issues and how to report these. There was an up to date safeguarding policy for children and young people and a separate policy for adults. There was a five stage procedure to follow regarding suspected abuse or risk of abuse which was clearly documented in the policy. Staff had not yet received safeguarding training and safeguarding issues were not a standing agenda item at team meetings. The staff safeguarding policy stated that all staff should receive training on safeguarding. There was a safeguarding committee which all managers within the organisation could attend. A new training matrix had been introduced and this included safeguarding as part of mandatory training. CQC had received no safeguarding alerts or concerns from Bridge House from January 2015 to January 2016. There was an up to date domestic abuse policy.

Substance misuse services

There was a medicines management policy which was due to be reviewed in March 2016.

Clients self administered their own medication. These were stored in locked boxes in clients own rooms. There were arrangements in place with a pharmacy to deliver all medications. When the medications were delivered they were checked in by clients or staff with their name and number of items delivered which were then signed for. However, the checking in process did not detail the names of each type of medication and this meant that there could have been issues with knowing what items had been received. When medications were given to clients to put in their own medication storage boxes in their room, this was signed and dated by the client and a member of staff.

We looked at eight clients' medication information which was kept in the staff office. Client photographs were kept in this file. All clients were given a medication administration record (MAR) sheet and a copy of this and a copy of the prescription was kept on file. All of the records we looked at were well organised, up to date and clearly stated which medications had been prescribed.

We looked at the returns form which recorded any medicines given back to the pharmacy. The returns were documented on a carbon copy paper form with one copy being given to the pharmacist and the other being kept on site. Returns were checked by the pharmacy and were up to date and accurate with the names of all medications specified in the returns.

Staff had a homely remedies procedure for the administration of paracetamol. The medication was kept behind a locked door which could only be accessed by staff who had the code. We saw that when staff gave clients paracetamol this was documented. This procedure was audited on a weekly basis.

Track record on safety

There had been one serious incident in the last 12 months involving the death of an ex-client. ADS serious untoward incident policy and procedure had been followed and the investigation was ongoing at the time of inspection.

Reporting incidents and learning from when things go wrong

Following any serious untoward incident staff and clients were offered support and debrief, as well as, access to external counselling if required. Lessons learned were fed back to the team at team meetings and through individual supervision. We looked at minutes of team meetings and found that learning from incidents was discussed.

Findings and outcomes of serious incidents were discussed at the safeguarding committee. The safeguarding committee identified and agreed measures to try and prevent future incidents from taking place. Anything agreed was then reported up to a professional committee who were responsible for advising in areas of professional and ethical practice in relation to the development of policies. These updates to practice and policy were then shared with the team at bridge House through the team meetings.

Duty of candour

Staff were not aware of the principals of Duty of Candour although they described working with clients in an open and honest way. The organisation had no policy on Duty of Candour.

Duty of Candour is a statutory requirement to ensure that providers are open and transparent with people who use services in relation to their care and treatment. It sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

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

Assessment of needs and planning of care

Two members of staff completed an assessment for each client prior to admission. This ensured that one person was able to actively listen and engage with the client while the other member of staff took notes. The assessment covered issues around personal history, education, employment, housing, finance and history of substance misuse. A decision was usually made on the day as to a clients' suitability for Bridge House. Depending on the outcome of the assessment the client would then be invited to visit to look round and see if they found it suitable for their needs. There was no waiting list for Bridge House at the time of inspection.

Substance misuse services

We looked at six care records and found that all had a recovery plan in place which was person centred and included a holistic overview of a clients needs, strengths and goals and these were regularly updated. All of the clients had been given a copy of their care plan.

There was a full physical health screen completed by the GP on admission and these continued throughout the clients' admission. Any relevant health concerns were detailed on the clients file. There were strong links with the GP surgery and clients could be seen quickly by them if necessary.

All clients files were stored securely in the office behind a key-coded door accessible only to staff. These were updated on a daily basis.

Best practice in treatment and care

There was a range of services offered at Bridge House. Groups and activities were mandatory and took place Monday to Friday. In the morning all clients completed daily jobs followed by individual sessions with key workers. After this there were different groups depending on what stage clients were at. These included a feelings group, recovery through art and life story work. After lunch there were further groups such as the men's/women's group and employability workshop. We observed some of these in practice including a cooking group and a leaving group. They were well structured and well facilitated. There were further individual sessions after the afternoon groups.

Staff were not aware of the National Institute for Health and Clinical Excellence (NICE) guidelines that had been produced in relation to substance misuse. For example NICE guidelines on drug misuse in over 16's: psychosocial interventions or alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. However; we observed that good practice was taking place throughout the service and these included cognitive behavioural therapy, counselling, group work, and family interventions.

Audits the service completed included a lifestyle outcome monitoring system which measured outcomes for clients with regard to abstinence from substance misuse. Bridge House submitted data to the national drug treatment monitoring system (NDTMS) which was used to assess and analyse outcomes for clients. This informed practice and also enabled the service to look at areas that needed development.

Feedback forms from carers were used to make improvements to the monthly family and friends meeting. Verbal feedback was gained from clients regarding their stay and there were forms available for them to provide written feedback although not all clients knew about these.

Skilled staff to deliver care

The staff at Bridge House were all suitably qualified. The team manager had recently undertaken level five management training and the deputy manager was currently undertaking this. Two staff had a diploma in counselling and one had an advanced diploma in counselling. Another member of staff had an NVQ level three in health and social care and advanced cognitive behavioural therapy award. The cook had completed level three food hygiene certificate and the administrator had completed level three in business administration. Volunteers had their own experience of addiction to draw upon when working with clients.

Additional management training offered to managers included supervision and appraisal, recruitment and risk assessments. Project workers were to be offered additional training in mental health, blood borne virus, conflict resolution, benefits, risk assessment, needle exchange and harm reduction, education, care planning, cognitive behavioural therapy, case management, enhanced safeguarding and family work.

We saw evidence that pre-employment checks were in place and these were up to date.

We looked at four supervision records for staff and found that staff were being supervised on a bi-monthly basis by the manager of the service. However the supervision policy for the service stated that staff should be supervised on a monthly basis. In addition, the supervision policy was dated 2009 with no review date. Counsellors had not received clinical supervision but there were plans for them to register with an accredited body which would require them to have clinical supervision.

We looked at three staff appraisals and found that two of these had been completed within the last year. The other had been completed in 2013. Overall, 75% of staff had an up to date staff appraisal. All staff attended the team meetings.

There was a capability policy which could be referred to that detailed processes in place if there were staff

performance issues. This included extra support through supervision and an action plan regarding improvements to be made which were monitored through supervision and additional meetings. There were no staff on performance management at the time of our inspection.

Multidisciplinary and inter-agency team work

We saw notes from team meetings which took place weekly. The standing agenda items for meetings were discussions from previous meetings, followed by organisation and performance, health and safety and any other business. We saw that these were well attended and staff were encouraged to discuss any issues in an open forum. Managers meetings took place on a monthly basis. We saw that information discussed in managers meetings was then discussed in weekly team meetings.

There were two handovers a day which were from the nightshift to the day shift and vice versa. At handovers there was a discussion around any issues from the previous shift and this was also documented in client's notes.

There were good working links with external services especially with the local GP and the pharmacy service. Clients were referred from all over the country and if accepted for admission into the service they registered with the same GP surgery who could provide appointments quickly. Staff remained in contact with the referring authority throughout the clients stay and they were invited to any relevant meetings.

The service had good links with local recovery communities such as the Lancashire user forum, red rose recovery, narcotics anonymous and other mutual aid groups. Clients would either attend these or a representative would come in and tell their story to a group.

Adherence to the MHA (if relevant)

The service was not registered to accept patients detained under the Mental Health Act, however there was recognition that the service was now accepting more clients with co-morbid mental health problems. The service had responded to this by including mental health awareness training in their new training matrix. Staff were aware of what to do if there was a deterioration in a client's mental health.

Good practice in applying the MCA

All clients who were admitted the service were presumed to have capacity to undertake the rehabilitation programme. The Mental Capacity Act (MCA) was not part of staff training and there was no MCA policy however there was a section in the safeguarding policy around this which detailed the five principles of the Mental Capacity Act. There was no procedure about what to do if there were issues with a client's capacity and staff were not aware of the principles of the MCA or what to do if a clients capacity were to change.

There were no clients subject to Deprivation of Liberty Safeguards.

Equality and human rights

We saw a policy for diversity and equality at Bridge House which covered all nine protected characteristics contained in the Equality Act 2010 – age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, and pregnancy and maternity. The policy was dated 2010 and had no review date.

There were few blanket restrictions as the service encouraged clients to take responsibility for their own actions. Clients were not given their own key to the building and had to be escorted when out of the building for the first three weeks after admission. There were also blanket restrictions on the use of drugs or alcohol and intimate relationships were not allowed between clients, however these were necessary and proportionate for the safety of the client and others.

Management of transition arrangements, referral and discharge

There were effective processes in place for transition into the community. Stage two of the treatment programme involved clients attending moving on groups and they were also encouraged to access community groups, education and volunteering opportunities in the wider community. Clients could be referred on to local agencies upon discharge from the service and referring agencies were always made aware of a clients discharge both verbally and in writing.

Are substance misuse services caring?

Kindness, dignity, respect and support

Substance misuse services

We observed staff speaking and working with clients and they were all treated with kindness, dignity, respect and support. All of the clients we spoke to felt valued and supported and said that staff were able to empathise with them. They commented that managers had an open door policy and would always talk to them.

There was a payphone in the corridor of the building which did not enable clients to have a private conversation, however they were able to use mobile phones in their rooms for private conversations.

We observed a leaving meeting for a client who had completed the rehabilitation program. All staff were present and gave positive feedback to the client about their recovery journey. Staff understood the needs of individual clients and this was demonstrated at the leaving group and during our own observations during the day.

The involvement of people in the care they receive

We looked at six care records and found that clients were actively involved in their care. They were encouraged to take responsibility for their actions and to maintain their independence and this was documented in care plans

There was a community meeting every week where clients could speak about any issues they had. Clients had individual support meetings with their keyworker on a weekly basis and staff could also be approached at anytime to speak to in private. All of the clients we spoke to said they would be confident to speak out if there was something concerning them. We saw in minutes of team meetings that client concerns were dealt with in a timely manner and fed back either individually or at the community meetings. The majority of the clients we spoke to were not aware that feedback forms were available but said they said could give feedback verbally. Any feedback given was discussed in team meetings and could be discussed at senior level if necessary.

A client survey had been completed in 2015 by six clients. All of the clients either agreed or strongly agreed that they felt safe, that it was easy for people to visit them, that the meals were of a good standard and that facilities were comfortable.

There was a monthly family group that carers and their families could attend. Here they could participate in group sessions and could also access individual meetings with staff. We looked at five evaluations of the day that were completed by carers or relatives. They noted that the day was very relaxed, informative and worthwhile. They said it was good to speak with others going through similar situations and a great help in their understanding of the therapeutic process at Bridge House.

We spoke with three carers whose relatives either had been or were still currently resident at Bridge House. All told us that the staff were excellent and went above and beyond what was required of them. They said that staff were genuinely interested in the recovery and wellbeing of their relative. One relative commented that the service had 'given them their Dad back'.

Clients were not routinely referred to local advocacy services but clients would be supported to access advocacy if necessary.

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

Access and discharge

Assessments for entry into the service were carried out by two members of staff. Specific information discussed included long-term needs assessment, assessment of motivation levels and the ability to engage in all rehabilitation activities. The client was given a copy of the residents handbook which included available treatments and expectations of the client. Arrangements were made for the client to visit so that the client could assess if Bridge House would be suitable for them. During the assessment process the client's personal history, education, employment, housing, finance and history of alcohol or drug use were all discussed.

A decision about whether a person was to be accepted for admission into the service would normally be given on the day of the assessment. Clients were all abstinent from drugs or alcohol on admission to the service.

Clients went through a two stage process when moving through the service toward independence. Stage one consisted of living in the main part of the house with their own bedroom, where it was expected that clients would learn to live as a community, supporting each other and

sharing any issues that arose in the early stages of their recovery. The second stage incorporated the use of six self-contained flats within the building and offered clients the opportunity to develop independent living skills.

There was no facility for urgent admissions to Bridge House however clients could be offered a place at short notice if they had previously agreed to this.

There was a discharge procedure at Bridge House. Clients attended moving on groups when they were at stage two of the programme and had discharge planning documented in their care plans. They were encouraged to engage in activities in the community to prepare them for discharge and clients could stay up to six months if they completed the full rehabilitation programme.

There were five rules at Bridge House which resulted in immediate discharge from the service. These were:

- Consuming alcohol or colluding with another resident in their consumption of alcohol or use of illegal drugs or non-prescribed medication.
- Failure to disclose to staff medication whichhad been prescribed.
- Violence, or threats of violence towards other residents, staff or visitors.
- Failure to pay or refusal to co-operate with staff in obtaining the weekly charge.
- Failure to behave as a satisfactory member of the house community.
- Residents must not become involved in intimate relationships with other residents.

For clients who had broken one of the five rules of the service there was an immediate discharge process in place whereby all appropriate agencies and relatives were contacted to ensure effective communication and the safety of the client upon leaving.

Bridge House also operated an open door policy, whereby ex-clients could call at the service and speak with staff. By arrangement, ex-clients could continue to access individual support and advice. There was an ex-clients support group every Friday and any ex-client could attend providing they were not using drugs or alcohol. A buffet lunch was provided and the group provided an opportunity for ongoing support of ex-clients as well as the chance for current clients to see how other had been successful in maintaining their recovery journey.

The facilities promote recovery, comfort, dignity and confidentiality

All clients were supplied with a bedroom key and they were able to lock their rooms and keep their possessions safe. Staff at Bridge House would not normally enter a client's bedroom or flat without them being present unless there was an emergency situation. Where staff needed to speak to a client we observed them knocking on their door and waiting for them to answer.

The use of restrictions in the service was minimal and this was to encourage clients to take responsibility for their own recovery however when clients were first admitted to the service they were allowed off the premises only with a member of staff or another client. If a client was on stage one of the treatment programme, televisions were not allowed in their room. Mobile phones were permitted but clients were asked to use them in the privacy of their own rooms. Lap tops were not permitted. This was explained to people before admission.

There was a payphone in the main corridor of the building that clients said did not afford them privacy however clients did have mobile phones which they were able to use in the privacy of their own bedrooms.

Meeting the needs of all people who use the service

There was a ramp to enable people with a physical disability to gain access into the building and a small lift to gain entry to the first floor however it was acknowledged by the provider that they were not able to accept admissions for clients who were wheelchair users or not able to use the stairs. This was because groups and mealtimes took place on the second floor. The provider did not have any alternative locations that could accommodate the needs of clients with physical disabilities.

We observed that the quality of the meals prepared by the cook was good and provided a range of healthy and nutritious foods. Clients on stage one of the treatment programme all ate together in the dining room. Stage two clients had their own kitchen facilities in the flats where

they could prepare and eat their own food. There was a buffet lunch prepared once a week that ex-clients were invited to which enabled them to chat or share their recovery stories in an informal way.

Interpreters including sign language interpreters could be accessed through the organisations head office.

There were different information leaflets regarding different drugs and alcohol misuse, mutual aid groups, harm reduction advice and advocacy services on display in the communal areas. These leaflets could be translated into a range of languages if necessary.

Clients' spiritual needs were discussed prior to admission and they were given information on local churches and spiritual centres in the area. Clients were aware that the residential service was located in an old Christian church prior to them accepting a place. This was to ensure that they did not have any objections to this.

Listening to and learning from concerns and complaints

The service had a complaints procedure which was detailed in the resident's handbook that was provided to every client on admission. There had been one complaint in the past 12 months. This was dealt with in house and upheld. The complaint was not referred to the ombudsman.

Are substance misuse services well-led?

Vision and values

The organisation had recently implemented vision and values. The vision of the organisation was:

- To be recognised as a leading progressive charity excelling in quality care, safety, support, research and innovation; dedicated to improving wider health and well being for our diverse population and communities.

The values of the organisation were:

- Compassion
- Consideration
- Dignity
- Empathy
- Pride
- Respect

The ethos of the Bridge House services was based on trust, responsibility and respect and we observed that this was clearly embedded in the culture of Bridge House both with staff and clients.

Senior managers across the organisation were well known and staff commented that they were approachable.

Good governance

The policies we looked at were of a good standard in terms of their layout and scope but some were not reviewed when stated and some had no review date. This meant that some policies including supervision, lone working, whistleblowing, grievance, employment, bullying and harassment, disciplinary, recruitment and selection, violence and aggression and data protection policy did not take into account new developments. In addition there was no Duty of Candour policy or Mental Capacity Act policy.

Outcomes for clients were measured by a lifestyle outcome monitoring system. This was completed by the manager of the service and then fed up to the wider organisation.

Staff appraisal rate was 75%. Although all staff had regular supervision this was not completed on a monthly basis as per the policy. The longest time period between supervision sessions was no more than eight weeks. There was a staff induction programme for all staff and a staff induction policy that was dated March 2006.

The team manager had access to administrative support and sufficient authority to undertake the role of manager.

We saw the risk register for ADS that Bridge House could submit items onto. Items could be submitted by the manager or other staff and items included risks around working with limited resources and costs. We saw that there was discussion around the impact of specified risks, mitigation of risk and strategies and actions for change. There was also a local risk register.

Leadership, morale and staff engagement

Sickness and absence rates were 3% in the period from January to December 2015 and remained low up to the time of the inspection.

There were no bullying or harassment cases and staff were aware of how to use the whistleblowing policy. They felt confident to raise concerns to either managers or senior managers and felt that any complaints would be dealt with in a fair manner.

The staff we spoke to felt a huge amount of job satisfaction. All three staff said they loved their job and that it was rewarding. Morale was good and the team worked well together. There was mutual support but boundaries were still maintained.

Staff demonstrated openness and honesty throughout the inspection however they were unable to tell us about the Duty of Candour regulation and there was no policy for this.

There were monthly meetings where all staff could feedback any ideas or issues they had and this would be given to senior managers or developed in house.

Commitment to quality improvement and innovation

Bridge House was not participating in any national service accreditation or peer review schemes at the time of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all existing policies are reviewed and updated.
- The provider must ensure that a Duty of Candour policy is developed and that staff are made aware of the principles of Duty of Candour.
- The provider must ensure that a Mental Capacity Act policy is developed and that staff are made aware of the principles of the Act.

Action the provider SHOULD take to improve

- The provider should ensure that the no smoking policy is adhered to.
- The provider should ensure that staff are aware of best practice guidelines including any relevant National Institute for Health and Care Excellence guidelines.
- The provider should ensure that all medicines checked in are itemised.
- The provider should ensure that supervision is provided in line with the company policy.
- The provider should ensure that the safeguarding training plan is fully implemented.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (Regulated Activities) Regulations 2014 Good governance How the regulation was not being met; The provider did not have systems or processes established and operating effectively to enable the service to assess, monitor and improve the quality and safety of the service provided. The service had a number of policies which had not been reviewed for up to nine years. These included supervision, data protection, lone worker, employment, bullying and harassment, disciplinary, grievance, recruitment and selection, whistleblowing and violence and aggression policy. The service did not have policies in place for the Mental Capacity Act or Duty of Candour. This meant that the provider could not be assured that staff were aware of and following the most up to date guidance and legislation. This was a breach of 17 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met; The provider did not ensure that care and treatment was provided in a safe way by ensuring that staff providing care or treatment to clients had the qualifications, competence, skills and experience to do so safely.

This section is primarily information for the provider

Requirement notices

Staff had not received training in the Mental Capacity Act and were not aware of the principles of the Act.

This is a breach of Regulation 12 (1) (2) (c)