

Littledale Hall Therapeutic Community

Quality Report

Littledale Hall,
Lancaster,
Lancashire,
LA29EY

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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

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

Overall summary

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

- The audits of medicines management arrangements were not sufficiently robust or recorded to ensure that the gaps in the medicines administration charts were identified and addressed. Staff were not always following the medicines policy the provider had in place. Where clients wanted to self-administer medicines staff were not risk assessing them.

Adequate checks to confirm what medicines clients were currently prescribed when they arrived at the service were not in place. Individual medicines records were not clearly presented and medicine records we looked at showed that doses of medicine were frequently missed.

Summary of findings

- The provider must ensure a ligature environmental audit is completed. This is to ensure that all that is reasonably practicable to mitigate any ligature risks is in place to ensure the premises are safe to use for their intended purpose.
 - The provider must complete and maintain contemporaneous record for each individual client.
 - Staff did not have a full understanding of their responsibilities to work within the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards.
 - Staff did not review the appropriateness of all blanket restriction practices in place for all clients at all stages of treatment. The restrictions were not individually risk assessed or reviewed throughout the course of the clients' treatment and the appropriateness of these was applied to all clients without applying any level of trust and or privacy as they progressed and neared completion of their programme.
- We found the following areas of good practice:
- The environment was clean, well maintained, welcoming and comfortable. Staff carried out assessments before clients were admitted to ensure that the service could meet the individuals' needs. Care plans and risk assessment were in place and were recovery focused. The provider reviewed the care plans regularly throughout a client's stay.
 - The therapies provided were underpinned by best practice. Clients had access to psychosocial therapies, group sessions and individual one to one sessions with a counsellor. Staff worked with clients to help them develop the skills they needed to sustain their recovery and maintain their independence when they returned to the community providing access to aftercare facilities to support them in their recovery.
 - Staff treated clients with respect and kindness and supported them throughout their stay.
 - All clients had full involvement with their treatment during their stay. They made decisions about their treatment during sessions with their keyworker.
 - There was a structured programme of care, therapy and activities. Discharge planning included an aftercare package to support clients following rehabilitation.
 - Staff had regular supervision, support and on going appraisals of their work performance from their managers.
 - Staff we spoke with were highly motivated in their work and told us they felt supported by senior management. There was an open and transparent culture. Staff told us they felt comfortable raising any concerns or issues.
 - There was an appropriate governance structure in place.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Littledale Hall Therapeutic Community	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the service say	6
The five questions we ask about services and what we found	7

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards	11
Outstanding practice	24
Areas for improvement	24
Action we have told the provider to take	25

Littledale Hall Therapeutic Community

Services we looked at

Substance misuse services

Summary of this inspection

Background to Littledale Hall Therapeutic Community

- Littledale Hall Therapeutic Community was a 31 bed residential addiction treatment centre providing accommodation for both male and female clients over the age of 18. There were 29 clients receiving treatment on the day of our inspection.
- The Hall is situated on the outskirts of Lancaster Lancashire, and is set within large grounds and open spaces.
- A large percentage of the placements are funded by statutory organisations, although clients are able to self-refer.
- Littledale Hall Therapeutic Community was registered to provide accommodation for persons who require treatment for substance misuse.
- There was a registered manager in place.
- The service was last inspected in January 2014 and was found to be compliant with fundamental standards of quality and safety at the time of the inspection.

Our inspection team

The team that inspected the service comprised of three Care Quality Commission (CQC) inspectors a CQC

pharmacist inspector and an expert by experience. 'An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.'

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with five clients who were using the service and throughout the two days we spoke with most clients who used the service
- attended and observed lunch being served
- spoke with the registered manager and the nominated individual

Summary of this inspection

- spoke with eight other staff members employed by the service provider, including a psychotherapist, admissions coordinator, an aftercare worker and support workers
- spoke with three peer support volunteers
- attended and observed a group education session
- spoke with a volunteer and an ex client
- reviewed five handover information sheets and their incident book
- collected feedback using comment cards from 19 clients, visitors or other professionals involved in the running of the service
- looked at the clinic room and the dispensing of clients medication
- looked at six client care and treatment records, including six medicines records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

All the clients we spoke with told us that they felt that the service was safe and welcoming. They told us that the staff were caring and courteous, very approachable and were always available to speak to if they needed further support. They told us that the staff were friendly and respectful, and that they always felt listened to by staff. They also told us their treatment and care had been clearly explained to them by staff as well as the expectations of the service.

We received 19 comment cards from people which included comments from clients, stakeholders and

referrers into the service. These were mostly very positive about the staff being caring, respectful, friendly and they were listened to. Two comment cards related to the food being cold and the environment not being hygienic. However, we did not find that cold food was a common complaint and found the location was clean, safe and well maintained.

All the stakeholder feedback we received from the comment cards described a safe service, which supported clients and achieved good outcomes.

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 issues that the service provider needs to improve:

- The audits of medicines management arrangements were not sufficiently robust or recorded to ensure that the gaps in the medicines administration charts were identified and addressed. The practice did not always reflect the policy the provider had in place. Medicines audits were not recorded and where clients wanted to self-administer medicines there were no risk assessments in place. Adequate checks to confirm what medicines clients were currently prescribed when they arrived at the service were not in place. Individual medicines records were not clearly presented and medicine records we looked at showed that doses of medicine were frequently missed.
- There was no ligature environmental audit in place to ensure that all that is reasonably practicable to mitigate any ligature risks has been identified and to ensure the premises are safe to use for their intended purpose.

However, we found the following areas of good practice:

- Staff demonstrated understanding of procedures for safeguarding clients from abuse.
- Staff had completed core skills training to their required level and their mandatory training.
- The environment at Littledale Hall was clean, safe and well maintained.
- Environmental, health and safety audits were in place.
- There was adequate staffing with very low use of agency staff.
- Staff had completed their mandatory training.
- All six of the client care files we looked at had a risk assessment and risk management plan in place where necessary.
- There was evidence of learning from incidents and feedback to staff.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All clients had a holistic assessment and up to date personalised care plan in place as well as discharge plans in place.
- Confidentiality and information sharing, and the treatment contract was discussed with clients and agreed on admission.
- Evidence based psychological therapies and group-based interventions were provided as recommended by the National Institute for Health and Care Excellence. Clients had access to psychosocial therapies, group sessions and individual one to one sessions with a counsellor.
- Staff had the necessary skills, experience, supervision and training to fulfil their role.
- Clients were discussed by the staff team daily in handover sessions. Clients did not attend but their opinions, thoughts and feelings were fed into the handover through completion of the daily slips that they completed each morning.
- Clients were required to attend a therapeutic recovery programme five days a week, and activities were available seven days per week and at weekends.
- There were effective multiagency and teamwork systems in place.

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

- Staff had not received training on the Mental Capacity Act 2005 and did not have an understanding of the Deprivation of Liberty Safeguards.
- Staff did not review the appropriateness of all the blanket restriction practices in place for all clients at all stages of treatment.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Staff were caring and respectful. Their interactions were person-centred, friendly, and recovery focused. Staff treated clients with respect and kindness and supported them throughout their stay.
- Staff established therapeutic relationships with clients and involved them fully in their care.
- All clients had full involvement with their treatment throughout their stay. They made decisions about their treatment during sessions with their keyworker.
- Clients were involved in the running of the house. They assisted on making lunches and helped to keep the house clean.
- Views of people and clients accessing the service had been sought and evaluated. This allowed feedback from clients to monitor the quality to improve the group work and 1-1 counselling.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Littledale Hall had full range accessible rooms to support clients' in their treatment and care pathway. Clients could also access a pleasant clean and well-maintained outside garden area.
- The service met the needs of all the clients who used the service. This included physical access into the building, their access to religious and spiritual support, ensuring that their dietary requirements were addressed.
- There was a structured programme of care, therapy and activities available. Informal activities were also available during the week, weekends and evenings.
- Discharge planning included an aftercare package to support clients following the completion of the treatment they received.
- Clients were listened to and had opportunities to raise a complaint or concern by varying ways.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Staff received regular supervision and ongoing appraisals of their work performance from their line managers, providing support and professional development so they were able to carry out their duties.
- Staff we spoke with were highly motivated in their work and told us they felt supported by senior management. There was an open and transparent culture and staff told us they felt comfortable raising any concerns or issues.
- All staff knew the senior managers by name. They told us that managers were approachable and available.
- There were local governance arrangements in place, including a range of performance indicators, policies, procedures and clinical audit.
- Staff and clients, families and carers were able to feedback into the service about their experiences of the care received.
- The company directors and senior managers completed reviews and audits that fed into the service governance structures to ensure that treatment and care was safe, effective, and continued to improve.

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

- The medicines audit had not identified or addressed the shortfalls we found.
- The provider had not maintained or completed a contemporaneous record for each individual client.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had not received specific training in the Mental Capacity Act 2005. Although they received very basic information as part of the safeguarding training, this would not fully equip them to understand their responsibilities in caring for clients who may, at times not have full capacity to make decisions.

Care records showed that clients had signed and consented to treatment, sharing of information and confidentiality agreements.

There was an organisational policy but staff were not confident in its application. This was because staff assumed clients had capacity when entering the residential service and seldom had to assess anyone's capacity.

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 premises were clean, tidy and well maintained. The atmosphere was welcoming and clients told us they felt safe. The main building, Littledale Hall was based over three floors with designated male and female sleeping areas. All of the bedrooms were shared apart from two bedrooms. One of these bedrooms was based on the ground floor and had been adapted for any clients with limited mobility as there was no lift facility at the location. There were bathrooms and toilets accessible for separate genders within the bedroom areas.

A health and safety audit was completed yearly. Local contractors were contacted to address any issues regarding the maintenance of the inside and outside of the building. A fire safety log book was maintained and weekly testing was completed. There was a fire risk assessment in place. All portable electrical appliances had been safety tested and were in date as well as an up to date gas safety checks covered by an up-to-date certificate. The local council completed checks on the water system yearly. This meant that the appropriate health and safety checks were carried out.

There was no ligature environmental audit in place. This must be implemented to ensure that where there are any identified ligature risks at the location then these are identified and mitigated against where reasonably practicable. This is to ensure the premises are safe to provide safe care and treatment and any avoidable harm should the client's risks change during their course of their treatment. The provider informed us that clients were fully assessed before admission and if a client posed a current risk to themselves or to others they would not be admitted to Littledale Hall.

The clinic room was clean and secure and only accessible by staff. There was a fridge to store medicines should this be needed.

A risk prevention plan and critical incident policy was in place to address any loss of services to the building. This included arrangements to respond to emergencies and major incidents. Bank staff would be used where there was any disruption to staffing if necessary.

Safe staffing

The service provided support 24 hours a day seven days a week. Clients could seek support from staff at any time. If urgent medical care was required, clients could attend the local GP service or access the local accident and emergency hospital if this was needed.

Staffing levels and skill mix were planned to meet the needs of the service. This comprised of 12 full time staff, four volunteers and four treatment practitioners. Staffing levels increased in 2015 to include a weekend worker, administrator and part time psychotherapist to meet the needs of the service. The service covered any staff vacancies or sickness within the main cohort of staff doing bank or overtime work to maintain staff continuity within their therapeutic environment until new staff were appointed. There was a staff member employed to provide cover throughout the home at night. The service had its own bank and a list of agencies but they had not had to use bank or agency staff since August 2015.

Staff planned their annual leave to ensure adequate cover. Any unexpected leave was managed through the goodwill of the team doing extra shifts. Staff and clients told us that the service never cancelled groups.

All new starters completed an induction process when commencing employment at Littledale Hall and all new staff were to undertake the care certificate as part of the

Substance misuse services

induction. The care certificate was developed nationally to provide common training standards across health and social care and has 15 assessed areas including caring, safeguarding, communication and privacy and dignity.

Mandatory training was up to date. Staff had regular management and clinical supervision and documents were in place to confirm this. Staff had also received appraisals, all staff had had an appraisal and they were present in all four files that we observed. We reviewed the annual training, staff development, and supervision and appraisal plan for 2016. This summarised and agreed priorities for 2016 and was reviewed regularly in the operational management meetings that were held every two weeks.

The service delivered their own training, which covered medicines management, emergency first aid, food health and hygiene, health and safety which incorporated fire safety, drug use and misuse, safeguarding, equality and diversity and mini bus driving awareness.

Access to specialist medical and mental health care was accessible through liaison with community mental health teams and specialist memory clinics as well as access to acute and primary care services.

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

We looked at six care and treatment records and generic risk assessments were in place. Risks were initially identified during the pre-admission process by the referrer to the service. Detailed risk management plans were in place where identified risks were present. We saw examples of this in two of the six records where clients had specific risk management plans in place to address issues of self-harm.

All clients on admission were registered with a local general practitioner to address their physical and mental health needs. Once a month an assessment was completed with staff and each client to address any on-going physical and mental health needs.

An incident book was completed daily and this was used as part of the daily handover to inform staff of any specific risk issues to ensure clients were safe. Staff used this to identify and respond to any changing risks as well as recording when clients had been tested for alcohol on return from home leave. This also recorded any changes in behaviour and information about clients' health and wellbeing.

A daily 'slip' system was in place for clients to identify any concerns or any escalating risk issues they may have. Clients met together to complete their own record of their thoughts, feelings and any issues they had. These were reviewed by staff and discussed where any concerns had been raised. Where concerns were raised these were addressed by the staff team and the clients.

The service implemented an 'in-out' sheet to record the whereabouts of all clients during the day. Additional to this the clients indicated themselves on a 'blob tree' to show their whereabouts within the building or when they are outside Littledale Hall.

All staff had been trained in first aid and any out of hour's physical health emergencies were managed by contacting emergency services and telephone support via the 111 service locally.

A discharge checklist provided 18 points of action staff implemented when a client left the service unexpectedly by discharging themselves. The checklist required staff to contact the client's care coordinator and funder and ensure the next of kin were informed. Staff provided details of mutual aid groups wherever possible as well as arranging transport for clients who were intent on discharge.

The service had an identified safeguarding policy in place. One safeguarding concern was raised in November 2015 where appropriate action was taken by the provider and this was then closed. All staff had undertaken level 2 safeguarding adults training, which was mandatory. All staff we spoke to had a good understanding of safeguarding procedures and knew when to make referrals as this was discussed daily in handovers and within staff meetings and supervision.

All clients and staff cleaned Littledale Hall daily. This included the outside areas. Staff checked the environment daily to ensure that it was kept clean and tidy. The service displayed infection control reminders around the building. A cleaning co-ordinator and a housekeeper were responsible for distributing cloths to the clients and a member of staff completed a house check every day to monitor infection control throughout the building. Mops and cloths used were colour coded for each specific area and were kept separate from bathroom mops and cloths. This meant that although clients had responsibility for cleaning the building as part of their recovery, staff checked that appropriate standards were maintained.

Substance misuse services

Support workers handling medicines had completed certificated training. Despite this, we saw shortfalls in the arrangements for managing medicines. The provider's medicines policy did not reflect actual practice in the service. For example, staff told us that clients were responsible for asking staff to order their medicines for them, but this was not described in the policy. A complete up-to-date audit trail of medicines ordered, received and administered was not maintained. Contrary to policy, clients wishing to self-administer medicines were not risk assessed by staff to ensure they could manage their own medicines safely. Clients who were self-medicating had access to lockable safes in their bedrooms where they could store their medication if needed.

Staff did not always complete adequate checks to confirm what medicines clients were currently prescribed when they arrived at the service. Similarly, changes to medicines were not well managed. One record showed that a client was not taking their newly prescribed medicines because they did not remember what the doctor had said. This had been raised with staff but was unresolved, six days later. Where staff took responsibility for client's medicines, individual medicines records were not clearly presented with three of the six records we looked at listing both currently prescribed and discontinued medicines.

Clients signed an agreement that they would arrive at the medicines room at the right times for their medicines, but they did not have a copy of their current medicines record to remind them when to do this. Four of the six records we looked at showed that doses of medicine were frequently being missed. This included critical medicines such as a course of antibiotics and a medicine for 'fits'. Staff told us that missing medicines would be discussed at handover. However, there were no records of these discussions within handover records, client's care plans, or assessments of any support they may need with their medicines.

Staff told us that checks of the medicines handling were carried out and that the findings were discussed at staff meetings. However, no records of these checks were made and there were no action plans to show how any improvements would be made.

Track record on safety

In the 12 months prior to our inspection, the service had one serious incident that required investigation. The incident was reported in November 2015 which was investigated by the provider and actioned appropriately in relation to safeguarding a client.

Reporting incidents and learning from when things go wrong

The service had a formal incident reporting policy and a daily incident book was completed as well as a full handover for staff twice a day. All staff received feedback from incidents informally with their manager and learning from incidents was cascaded via team meetings and supervision sessions. Staff held group sessions and discussions to support clients if needed after an incident.

Staff had implemented changes to practice following lessons learnt from concerns raised. An example of this was an incident where a care plan was late in being sent to the client's care coordinator. This had been addressed by setting up weekly communication to update and inform the care coordinator about their client's progress.

Staff told us they were supported following any incident or serious event as needed by the management team and other staff.

Duty of candour

The service had a duty of candour policy in place. Duty of candour regulations set out some specific requirements that providers must follow when things go wrong with care and treatment, including informing clients about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff were not able to specifically tell us about the Duty of Candour principles. Although the provider had highlighted this policy for staff to familiarise themselves with. There had been no significant incidents which met the Duty of Candour threshold.

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

Assessment of needs and planning of care

Prior to initial assessment with the client, staff gathered information from referring agencies. Staff then completed a holistic assessment with the client which included basic details, history of substance misuse and triggers, mental

Substance misuse services

health issues, relationships and details of housing, employment and education. The assessment focussed on a clients' readiness for treatment and their motivation to change.

We looked at six care records and found that all of the assessments and care plans were up to date. Care plans were based on the six cornered addiction rescue system and highlighted the areas of accommodation, employment, physical health, addictions treatment, significant relationships and psychological health. Care plans were completed collaboratively with the client and their allocated treatment practitioner. Care plans were all personalised and clients had the opportunity to write additional comments regarding their care plan in the comments section.

The manager of the service carried out checks of care plans to ensure they were up to date and of good quality these were then signed off. We saw that all care plans were reviewed at the one month and three month stage of treatment. They could also be reviewed in between these times if necessary. However, staff did not complete daily contemporaneous notes for each client. This meant that patterns or themes around a client's behaviour, mental health or physical health could be missed. The handover record was the main care record kept, as staff did not complete daily notes for each client.

We saw that confidentiality and information sharing was discussed during the assessment process prior to admission and a form was signed by the client to say that they agreed to this. It was then stored in individual files.

Details of the initial assessment, risk assessment and confidentiality agreements for each individual client were stored in a filing cabinet which was locked at the end of each day. Care plans, advice and guidance sessions and other details were completed on an electronic records system and were then printed off and kept in an individual file on shelves in the staff room. When clients moved between services or were discharged from Littledale Hall, all relevant information was transferred over and a discharge plan was completed to ensure a safe and effective transition.

Littledale Hall had a rolling programme of treatment available five days a week which was linked to the five therapeutic stages of treatment. The groups included a community group each morning and evening where clients

could raise any immediate issues. Other groups included the neurological, biological, psychological and sociological aspects of addiction, recovery, parenting, computers, relationships and psychodrama. Evenings and weekends were spent in a more relaxed manner and included regular weekly pamper nights and cinema nights. Family visits took place at the weekend. Clients also completed daily chores throughout the day including cleaning and cooking.

Best practice in treatment and care

The treatment programme at Littledale Hall was built around five key treatment stages which were belongings, safety, openness, participation and citizenship and empowerment. This provided a recognisable framework to enable staff and clients to talk about their progress through the programme in a structured way.

Clients physical health needs were assessed by the GP service. Clients' medication was also reviewed by the GP. Clients were encouraged to go to a local gym or undertake other physical exercise such as cycling. The Eat Well Guide, published by Public Health England, was used by staff and clients to look at ensuring that clients ate a healthy balanced diet.

National Institute for Health and Care Excellence guidelines and practice were implemented at Littledale Hall. Littledale Hall routinely worked with reference to quality standards (QS23) and measures to improve the effectiveness, safety and experience of care for clients.

All clients had an in house assessment prior to going to Littledale Hall and, as part of this, the assessment coordinator liaised with and collated information from a range of external sources in line with Quality Statement 2 Assessment.

All clients were offered screening and treatment for blood borne viruses through the local doctor whilst they were resident at Littledale Hall. An expert by experience routinely provided information about their experience of treatment for Hepatitis C for those clients who were affected. This meant the service worked within the Quality Statement 4 on blood borne viruses.

All clients completed their own discharge plans and worked with the aftercare worker alongside their keyworker to minimise the likelihood of relapse. Most staff had completed initial motivational interviewing training. Staff routinely provided brief motivational interventions as part

Substance misuse services

of routine daily interactions with clients. Littledale Hall also provided psycho-educational groups that focused on a range of issues that are associated with addiction and recovery (e.g. NeuroBioPsychoSocial group). Clients had access to key working psychosocial interventions as stated in Quality Statement 6.

Staff integrated psychodrama groups for clients assessed as likely to benefit from this intervention. Staff also incorporated mindfulness groups into the programme (through an external partner agency facilitator). Clients were supported to access online self-help cognitive behavioural therapy services (e.g. Mood Gym). Key workers also encouraged clients, where appropriate, to access psychological therapies as part of their discharge plans. This meant that the service also met Quality Standard 8 on formal psychosocial interventions and psychological treatments

Littledale Hall offered a structured modified therapeutic community that incorporated principles from the psychologically informed environment project (a project of the Royal College of Psychiatrists) to maximise the opportunities available to clients to identify and work with thoughts, feelings and behaviours that contributed to, or were associated with, their addiction. The structured environment and interventions offered supported a consistent and considered approach to identifying and managing risks, triggers and responses that may lead to relapse to support on-going recovery. This meant that Littledale Hall met Quality Standard 10 residential rehabilitative services.

Whilst it was clear that the staff were using best practice methods, the staff we spoke with were not fully aware that the work they did was underpinned by National Institute for Health and Care Excellence guidelines. However, we saw that these guidelines were discussed in staff meetings.

Self-help and peer support were all used to ensure that clients could start to build confidence and develop skills that may have been lost due to substance misuse. Building relationships with families and re-establishing relationships was also seen as part of the recovery process at Littledale Hall and family work could be undertaken where necessary.

Specialist counsellors external to the service could be accessed if a client had specific issues. A psychotherapist on site could offer treatment to clients who had experienced trauma.

Clients were supported to access appropriate employment, volunteer opportunities in the community and we saw that clients had been supported to make housing applications where necessary.

Littledale Hall used treatment outcomes profiles to submit data to the national drug treatment monitoring system which was used to assess and analyse outcomes for clients. This informed practice and enabled the service to look at areas that needed development. Staff also worked within workforce standards and guidance. For example, drug and alcohol national occupational standards and skills for care standards to support staff and promote high quality care.

Skilled staff to deliver care

Staff at Littledale Hall were all suitably experienced and qualified and they included counsellors, support staff, treatment practitioners, a psychologist and administrative staff.

If staff wanted to carry out specialised training it was discussed with managers or human resources and they could then access this if it was appropriate to service need. Specialist training that had recently been completed included psychodrama, trauma, motivational interviewing and counselling. Most staff had level two or three National Vocational Qualification in substance misuse.

Staff were supervised in group meetings and these were facilitated by the psychologist based at the service. Supervision was for two hours on a monthly basis. We saw four records of group supervision and these were all documented on a group supervision and reflective practice record. Copies of group supervision were available in the supervision file, in the staff office and in individual staff files. In addition to group supervision staff were able to talk informally on an individual basis with the manager if they had any concerns or issues that needed to be raised.

We found that care and treatment was not cancelled by the service. We spoke to staff, clients and past clients who confirmed that the service did not cancel or delay any activities. Staff were available to cover sickness and absence.

Substance misuse services

Appraisals were completed on a yearly basis by the registered manager for the home. All staff had received an appraisal within the last year. The appraisal included 360 degree feedback as part of the appraisal process. This system meant that staff received confidential, anonymous feedback from the people who worked around them, enabling them to further develop an appreciation of how they worked with others. Staff learning needs were addressed at both appraisal and supervision.

During the inspection we looked at four staff personnel files. The files were well organised and contained all relevant information which included the staff induction training programme which was signed and dated, training certificates, sickness records and return to work interviews.

The staff files reviewed had all had been checked by the disclosure and barring service. This meant that before people were employed checks were in place to ensure staff working at Littledale Hall were of good character. We also saw driving licence and insurance details, current disclosure and barring certificates, reference checks, and statement of main terms of employment and application forms.

The service identified and addressed poor performance promptly. The management would oversee and implement a capability procedure which was detailed in the employee handbook. There was no staff that were subject to performance management at the time of the inspection.

Multidisciplinary and inter-agency team work

Clients received care from a range of professionals which included social workers and care coordinators, private and voluntary organisations and other professionals. We looked at three sets of minutes from team meetings that took place on a weekly basis and these were well attended by staff. There were standing agenda items discussed each week although actions from previous meetings were not discussed which meant that it was not easy to track if tasks had been completed. The senior management team met on a fortnightly basis.

We saw evidence of recent handovers. Handovers were completed on a daily sheet and included significant client events, actions taken and outcomes. There were discussions around advice and guidance given to clients, medications, safeguarding issues, incident book entries, health and safety issues, external communications and issues to follow up. The handover sheets that we saw were

detailed and comprehensive. However they did not record who was present at handover which meant that the provider could not identify which staff had received the handover information.

Adherence to the MHA

The service was not registered to admit clients detained under the Mental Health Act.

Whilst staff had not received formal training in mental health, staff were aware that if a clients' mental health was deteriorating they could refer to the general practitioner, local crisis team or to the local community mental health team for advice.

Good practice in applying the MCA

Care records showed that clients had signed and consented to treatment, sharing of information and confidentiality agreements.

Staff had not received specific training in the Mental Capacity Act 2005. Although they received very basic information as part of the safeguarding training, this would not fully equip them to understand their responsibilities in caring for clients who may, at times not have full capacity to make decisions.

There was an up to date policy on the Mental Capacity Act which could be accessed via a quality compliance system. All staff had been given access to this. Managers told us that if there was an issue with a clients' capacity it would be picked up in handover and a referral would be made back to the clients' case manager. However staff told us they were not aware of the Mental Capacity Act and its principles. This meant that staff did not fully understand their responsibilities and any capacity issues might have been missed. There were some clients with a learning disability or memory problems; we did not see any consideration of capacity in the records we looked at.

There were no clients subject to Deprivation of Liberty Safeguards.

Equality and human rights

All staff had recently undertaken training on equality, diversity and human rights and there was an up to date equality and diversity policy that staff had access to.

Substance misuse services

Staff from Littledale Hall staff supported clients to access local lesbian, gay, bi-sexual and transgender groups. Littledale Hall had been awarded a charter mark for their work undertaken with the lesbian, gay, bi-sexual and transgender community.

There were ramps into the building and a downstairs bedroom for clients with limited mobility. However, the service acknowledged that there were limitations with access to parts of the building for clients with mobility problems. There was one volunteer who used a wheelchair and they were supported to access different parts of the building. The use of blanket restrictions in the service was kept to a minimum but did include restrictions on the use of mobile phones, phone calls which were limited to four 15 minute phone calls a week, visits from or to family and friends once every two weeks and town visits every two weeks. Clients consented to these restrictions as they were intended to promote recovery from addiction. Internet access was available in a separate building but this was monitored to prevent clients accessing illicit material on the internet. In addition, clients had to complete a movement sheet every time they went to a different part of the building so that clients' whereabouts could be identified for fire safety purposes and to ensure clients were safe. Intimate relationships between clients were not permitted at Littledale Hall.

Letters were read with staff and the client present prior to clients receiving them. The contents were scanned and any outgoing mail was also checked with the client by a staff member. The client signed to confirm they agreed to Littledale Halls rules on assessment and before being admitted. These were devised to provide a safe environment and linked into the safeguarding policy, risk taking policy and the use of alcohol and substances by visitors, clients and staff. The use of restrictions in the service were implemented to ensure that the clients could focus on their recovery and to avoid any disruptions to their treatment. However, these restrictions were not individually risk assessed or reviewed throughout the course of their treatment and the appropriateness of these was applied to all clients without applying any level of trust, positive risk management and or privacy as they progressed and neared completion of their programme.

Management of transition arrangements, referral and discharge

There were effective processes in place for transition into the community. Clients were encouraged to access community groups, education and volunteering opportunities in the wider community as part of their transition back into the community. Clients could be referred on to local agencies upon discharge from the service and referring agencies were always made aware of a client's discharge both verbally and in writing. There was a procedure for unexpected discharge and we saw a discharge checklist which staff used to ensure that all processes had been completed correctly.

Are substance misuse services caring?

Kindness, dignity, respect and support

Staff respected clients and valued them as individuals. We saw staff treated clients with dignity, respect and kindness; the relationships between them were positive. Client's feedback was positive about the way staff treated them. There was good engagement between staff and clients. Clients told us they felt supported and said staff cared about them. They described staff as friendly, approachable, courteous, helpful and knowledgeable.

There was a strong, visible person-centred culture. Relationships between clients and staff were caring and supportive. These relationships were valued by staff in a professional manner and promoted by managers within the therapeutic community. We observed a client asking to talk to a member of staff and this was facilitated in a respectful and calming manner in a room where other clients or visitors could not overhear.

Staff and clients were aware of the need to respect people's privacy and promoted the need for confidentiality, particularly in groups where personal information might be shared as part of the therapeutic process. Clients told us staff where compassionate they all agreed that the staff were like family to them and felt staff showed empathy towards them.

The involvement of people in the care they receive

Before their admission, clients received information about the service and visited Littledale Hall. Clients at Littledale Hall showed new clients considering accessing the service around the building. They were invited to attend Littledale Hall for a day before they were admitted. They were

Substance misuse services

provided with an information pack about their stay at Littledale Hall during the admission process. This was to ensure clients understood the ethos and restrictions in the programme.

During the admission process, a client was allocated a 'buddy or mentor' so that they were orientated to the building and supported during their first few days of admission.

Littledale Hall held family days throughout the year and clients were able to see family members every two weeks. Children were able to visit onsite and a family room was available. Family feedback forms were also available.

Local and external support groups were available to help individuals with their recovery and advocacy was available to support clients if needed.

Clients were able to input into the treatment and care they received through completing a daily 'slip'. The daily 'slip' system was in place for clients to identify any concerns or any escalating risk issues they may have as well as a way of clients recording their own thoughts, feelings and any issues they had. These were reviewed by staff and discussed where any concerns had been raised. Where concerns were raised these were addressed by the staff team and the clients.

We found clients were involved and updated about their care and progress at all times during their stay. Clients were provided with individualised treatment plans. These included attendance at some mandatory group meetings. Individual one to one meetings and counselling meetings were also available. Clients were encouraged to provide feedback about the group work they had attended.

Views of people and clients accessing the service had been sought and quarterly evaluations of group work and one to one counselling provided had been completed. This allowed feedback from clients to monitor the quality to improve the group work and one to one counselling. An action plan had been produced with recommendations to ensure the group work met the needs of the clients.

Clients were involved fully and were supported by staff, care coordinators during the referral, transfer and discharge process. Clients were involved in the recruitment of new staff and scored candidates after a presentation. These scores were used to inform decisions when recruiting staff.

Policies, procedures and information were in place to inform clients (and those close to them) to help them understand how they may be involved in their care and treatment where necessary. Emotional support and family work could be provided to client's relatives including carers and dependants.

Clients were enabled to have contact with those close to them and to link with their social networks or communities where this was appropriate. We saw that staff at Littledale Hall encouraged, supported and maintained links for clients to continue with healthcare treatments they had established before their admission.

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

Access and discharge

The service employed an admissions coordinator who was responsible for the referrals, initial assessments and admissions process. Clients were referred by local authorities and then invited to attend for a face-to-face assessment at the service. This also included introducing the client to the environment and an opportunity to meet other clients. We examined referral, assessment and admission data which demonstrated that initial assessments were completed in a timely manner following referral. Clients were supported to attend the service by the admissions coordinator who liaised with the referrer and client. However, admission to the service was not immediate due to the high amount of referrals received. This was managed by the senior management team who met weekly to discuss the waiting list and the next most appropriate admission. This was based upon the needs of the client and the length of time on the waiting list.

Admission dates were dependant on the completion of detoxification programmes provided at other services. The average bed occupancy rate for three months prior to inspection, (January to March 2016) was 76%. The service ensured that a bed was available for clients following detox.

The service had a clear admissions criteria which excluded clients with greater care needs. This included clients with psychotic illnesses and clients with high risk offending behaviour such as arson or sexual crimes.

Substance misuse services

During the 12 months prior to inspection (January to December 2015) the service admitted 90 clients. Fifty-eight successfully completed their period of treatment and were discharged to appropriate housing with support.

We saw discharge plans which were clear, comprehensive and detailed and ensured that clients and others involved in their care were aware of on-going recovery plans as well as plans for housing, employment and family life. There was a discharge checklist that all staff used to ensure that clients received appropriate advice and guidance including discussion around harm reduction that relatives and funders had been contacted, three days of medication had been provided and appropriate transport had been arranged.

We examined the discharge procedure and found that clients who self-discharged prior to completing the programme were supported appropriately. This included liaising with commissioning teams, escorting the client to the train station, advice on options for treatment and safety and allowing the placement to remain open for 48 hours.

Clients could access an additional 12 month aftercare package if they completed their treatment programme. This provided a weekly recovery maintenance group, 1-1 advice and guidance sessions on individual recovery plans and client could attend social activities. This was delivered in partnership with relevant and external agencies as well as having an experienced addiction practitioner.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a full range of rooms and equipment to support treatment and care. This included two lounges and a dining room on the ground floor. These were used for group and individual sessions.

Clients could meet with visitors at weekends. A room was designated for children visiting and a booking system was in place.

The service provided a space for clients to make telephone calls. This was on the landing of the first floor. Privacy was limited as other clients or staff were able to overhear, as this was an open plan area.

Clients had free access to outdoor space during the day time. The service had pleasant lawned garden areas which contained flowers, trees and shrubbery.

Clients were responsible for all meal preparation which included choosing a menu and cooking the food. Clients told us that the food was of good quality and quantity. However, two clients did complain about food being cold.

Hot drinks and snacks were available at all times. These were located in the entrance area of the building.

We looked at all male and female bedrooms and found that clients were able to personalise their bedrooms. Bedrooms were kept tidy and photographs and other items were on display. Clients were able to access their rooms during the day but were required to inform staff by checking in to ensure their whereabouts.

All clients had a safe in their bedroom areas which could also be used to store medication for clients who were able to self-administer their medication. However, we found that these were rarely used. Clients told us they kept their money, mobile phones and other items with staff for safe keeping. Both staff and clients confirmed there was no issue with theft of belongings.

The service provided structured activities during the week. These included,

- twice daily community meetings
- twice weekly bio neuropsychosocial groups
- daily belonging group
- weekly group sessions relating to safety, openness, empowerment and participation and citizenship
- weekly parenting group (for either those with children or wider parenting issues)
- weekly relationship sessions
- individual counselling sessions
- weekly drama groups, (run over eight weeks)
- reflective time (every evening)
- daily department duties (cleaning, cooking, gardening, maintenance)

Informal activities during the week, weekends and evenings included,

- social activities (run by the volunteers)
- support chairs (topical discussion initiated by clients)
- cinema nights (every Friday)

Substance misuse services

- pamper nights (watching TV and beauty treatments)
- exercise (walking, running, table tennis, gym)
- fishing, rounder's, bowling (organised by clients)

The service was also involved with projects run by the National Trust. This allowed clients to experience working in the outdoors with nature and conservation.

Meeting the needs of all people who use the service

Referrals were accepted from local authorities countrywide. The service sought feedback from clients, referrers, families and carers and adapted accordingly. This involved looking for trends in data and reviewing practices where necessary.

The service was aware of the needs of different clients and provided ground floor accommodation for those with mobility needs. The service was wheelchair accessible on the ground floor. A wheelchair user was a member of the staff team. The service had identified that older clients were being referred and aimed to allocate single rooms to this client group. Staff considered client's religious needs; clients had access to the local church and prayer materials and specific food to meet client's cultural and spiritual needs could be arranged if necessary.

During the assessment process and on-going throughout their stay, clients were provided with additional support for any identified needs including any individual with a learning disability. Staff gave an example about supporting clients with dyslexia where staff spoke with clients about how best they could meet their needs. This involved specific access to computer programmes and care plans formatted onto specific coloured paper.

Access to language interpreters, sign language interpreters, specialist advice or advocates were accessible if needed to meet the needs of all clients that accessed Littleddale Hall.

The service had formed links with lesbian, gay, bisexual or transgender community groups in the local area and staff would support clients to attend. Victims of domestic abuse and childhood abuse were offered support in individual and group sessions within the service. The service had also made links with outside counselling organisations for more in-depth therapy. The service was aware to refer clients to the appropriate mental health team if appropriate.

Listening to and learning from concerns and complaints

Clients were able to make a complaint via the following options,

- completing an advice and guidance form which were available within the service
- during daily handover meetings which staff and clients attended
- client comment book
- feedback with staff following assessments and care planning sessions
- during case reviews with clients and other agencies
- feedback was encouraged during the initial visit to the service
- client feedback was sought following the completion of treatment

Clients and families and carers were given an information booklet during the admission process. This booklet explained how to make a complaint which included via the website for families and carers. We examined the complaints information and found that the service had received one complaint in the 12 months prior to inspection.

The service had received a comment that client documents were not being shared with the referring agency in a timely manner. The service had reviewed this procedure and implemented a new system to rectify this issue.

Learning from complaints was discussed with staff during meetings and supervision sessions.

Clients we spoke with said they would feel confident speaking to staff regarding making a complaint.

Are substance misuse services well-led?

Vision and values

The service has a statement of purpose in place, which was accessible on their website. Their aim was to promote a safe, supportive and secure setting, which promoted opportunities for clients to explore and address psychological, emotional and social issues that can help them recover from their addiction. Staff understood the vision and values of the Littleddale Hall.

Substance misuse services

Staff understood the principles of the therapeutic treatment programme and about how their work linked in.

Good governance

There were local governance arrangements in place to ensure good quality care. These included regular audits these included training, food audit evaluations, annual analysis of group evaluations. Managers also monitored their admissions and discharges into and out of the service monthly as well as treatment monitoring for every client entering the treatment programme.

Managers told us that staff audited their medicines weekly and checked medicines administration record sheets monthly. Staff told us that checks of the medicines handling were carried out and that the findings were discussed at staff meetings. However, no records of these checks were made and the provider had not identified or addressed the shortfalls in the medicines management arrangements. There were no action plans to show how any improvements would be made.

Following our inspection information was received to confirm that managers had implemented a new medicines audit and system to improve the issues raised during the inspection.

Records confirmed that the director of the company also presented a report prior to the operational management meetings. A project report was also available at these meetings. This enabled the management team to have good oversight of all areas of the business including operational, financial and developmental issues as well as any risk issues. Terms of reference were in place for these meetings to inform senior staff of their participation and requirements at these meetings.

We found all the staff were well managed. The management team were experienced and had a presence at the service to ensure that high quality, person centred care could be delivered. Staff were clear about their roles. They received appropriate training and supervision as well as group supervision and reflective practices. We were assured that staff were competent and had the skills necessary for them to carry out their roles. There was a shift handover meeting that all staff attended to ensure they were kept up to date and informed about the clients they provided a service to.

Views of clients accessing the service had been completed and this was on going and completed quarterly. The delivery of group work and 1-1 counselling had been evaluated. This allowed feedback from clients to monitor the quality and agree changes to improve the group work and 1-1 counselling sessions. An action plan had been produced with recommendations to ensure the group work met the needs of the clients.

Littledale Hall used treatment outcomes profiles to submit data to the national drug treatment monitoring system which was used to assess and analyse outcomes for clients. This informed practice and enabled the service to look at areas that needed development. The commissioners and Public Health England monitor the effectiveness of services and ensure they continue to meet the needs of the local population.

The service had a critical incident policy in place and a risk mitigation plan. The service had implemented a 'policy of the month' initiative. When staff logged onto the computer system a policy would be displayed for staff to read and familiarise themselves with. Littledale Hall had accessed an external company to assess their compliance in relation to health and safety management.

A review of the service that was provided by Littledale Hall was due to be completed by October 2016. This would take into account client feedback and internal and external monitoring. There had been one quality visit undertaken in the last 12 months in December 2015 by senior managers.

Leadership, morale and staff engagement

The registered manager had been in post less than a year having worked at the service for a number of years. They said they felt well supported by the senior management team. Staff told us they felt well supported by their colleagues, the manager and the organisation. The service had a low sickness rates among staff and staff morale was good. Staff found their work fulfilling and stated they enjoyed working at Littledale Hall

Staff were aware of the whistleblowing process and said they would use it if they felt it was necessary. They told us they felt able to raise concerns without fear of victimisation and would not hesitate to inform management.

Substance misuse services

Staff were encouraged to discuss issues and ideas for service development within supervision, and team meetings and the manager had an open door policy so that staff could discuss any issues they had.

There was strong collaboration and support across the service and a common focus on improving quality of care and clients' experiences. Staff were proud of the service as a place to work and they spoke highly of the culture and place they worked.

Commitment to quality improvement and innovation

The provider responded to feedback from clients, staff and external agencies. Clients were asked for feedback during their stay and were encouraged to make suggestions during their stay also.

Internal monitoring systems were in place to look at themes, such as data about varying stages of clients' treatment and at what stage they had been discharged or had discharged themselves. These were used to monitor the effectiveness of the service. There were regular audits completed throughout the year, with timed action plans for improvements based on the findings.

There was a strong focus on continuous learning to meet the needs of the service being delivered. Staff were encouraged to review their performance and make improvements through supervision and appraisal. There were opportunities for staff to learn and improve their practice, for example, reflective sessions in group supervisions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

Action the provider **MUST** take to meet the regulations:

- The provider must ensure audits are documented and implemented in relation to medicines management and ensure their practice is reflective of the policy in place. Risk assessments must be in place for clients who are able to self-administer medicines. This is to ensure clients receive and are provided with safe care and treatment in relation to medicines management.
- The provider must ensure a ligature environmental audit is completed. This is to ensure that all that is reasonably practicable to mitigate any ligature risks is in place to ensure the premises are safe to use for their intended purpose.

- The provider must complete and maintain contemporaneous record for each individual client.

Action the provider **SHOULD** take to improve

- The provider should ensure all staff receive training on the Mental Capacity Act 2005 and have an understanding of the Deprivation of Liberty Safeguards.
- The provider should review the appropriateness of all restrictions in place for all clients at all stages of treatment.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users. The registered person must ensure that the proper and safe management of medicines are provided in a safe way for clients. And assess the risks to the health and safety of the service users doing all that is reasonably practicable to mitigate any ligature risks to ensure the premises are safe to use for their intended purpose.</p> <p>How the regulation was not being met:</p> <p>We found that clients were responsible for asking staff to order their medicines for them, but this was not described in the policy and a complete up-to-date audit trail of medicines ordered, received and administered was not maintained.</p> <p>Clients wishing to self-administer medicines were not risk assessed.</p> <p>Staff did not always complete adequate checks to confirm what medicines clients were currently prescribed when they arrived at the service.</p> <p>Individual medicines records were not clearly presented in three of the six records we looked at. Four of the six records we looked at showed that doses of medicine were frequently being missed.</p> <p>The audits of medicines management arrangements were not sufficiently robust or recorded to ensure that the gaps in the medicines administration charts were identified and addressed.</p> <p>There was no ligature environmental audit in place. This must be implemented to ensure that where there are any identified ligature risks at the location then these are identified and mitigated against where reasonably</p>

This section is primarily information for the provider

Requirement notices

practicable. This is to ensure the premises are safe to provide safe care and treatment and any avoidable harm should the client's risks change during their course of their treatment.

This is a breach of Regulation 12 (1)(2)(a)(b) (d)(g)

Regulated activity

Accommodation for persons who require treatment for substance misuse

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes must be established and operated to maintain and accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.

How the regulation was not being met:

Daily contemporaneous records for each client were not maintained. The handover record was the main care record kept as staff did not complete daily contemporaneous records for each client.

This is a breach of Regulation 17 (1) (2) c

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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