Yeldall Christian Centres

Yeldall Manor

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Yeldall Manor is a male only Christian substance misuse residential rehabilitation centre that provides an abstinence-based programme. It does not provide detoxification programmes. It previously had 25 beds, but it is being converted to provide 21 en-suite single rooms.

We rated this service as good overall because:

- The service provided safe care. The premises where clients were seen were safe and clean. The service had enough staff. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

However:

- The service was not auditing Infection Prevention and Control (IPC) and cleaning therefore opportunities to make improvements were missed.
- The recording of documentation for cleaning records, the training matrix and changes from lessons learnt, did not always allow the service to provide clear evidence about the quality of the service.
- The service was not communicating clearly to clients how support for relatives and loved ones was taking place. There was evidence of relative and carer involvement, but clients report that this was not routinely offered.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Good 	We rated this service as good overall because it was safe, effective, caring, responsive and well-led. See overall summary.

Summary of findings

Contents

Summary of this inspection

Background to Yeldall Manor

Yeldall Manor is a male only Christian residential rehabilitation centre. It previously had 25 beds, but it is being converted to provide 21 en-suite single rooms. The service is a charity organisation operating under the provider Yeldall Christian Centres. It has operated as a rehabilitation centre for 40 years. It receives referrals from local authorities across the UK and also self-funded clients. The provider also offers a bursary, funded by Yeldall Manor via fundraising, for people unable to secure local authority funding.

The abstinence-based programme consists of four phases however only phase one and two are regulated by the CQC. Phase one offers grounding and stabilisation and is 12 weeks in duration. Phase two includes offers growth empowering clients to advance in recovery skills and is 12 weeks in duration. Both phase one and two include one to one counselling and group sessions with work in the house and grounds. Phase three is 18-24 weeks and offers recovery support with the availability of three self-contained flats. Phase four is for 12 months and community based where clients are supported to explore training and employment. The service also offers five move-on houses for clients who reach phase four, and aftercare for 12 months following completion.

The service does not currently provide alcohol or opiate detoxification.

The service has been registered with CQC since 1 October 2010.

A registered manager was in post at the time of the inspection.

We carried out this inspection as part of our ongoing comprehensive inspection programme.

This service was last inspected in May 2018 where we served requirement notices under Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 18 HSCA (RA) Regulations 2014 Staffing. On this inspection we saw the breach of regulations was resolved.

This is the first time we have inspected and rated the service under our new methodology.

What people who use the service say

We spoke to five clients during the inspection. Generally, feedback was positive. Clients told us they regularly met with their recovery worker and counsellor and were happy with the support they received. Clients praised the activities on offer as part of the treatment programme and all said that they would like more of these. Clients commented that the food was good quality however they would like the opportunity to cook for themselves as only clients on phase three and four of the programme cook meals for themselves. For example, there was a microwave that clients were not allowed to use whilst on phase one and two of the programme.

Clients fed back that they had mixed views on the programme that had been restructured in the light of COVID-19. Some clients appreciated having more 'down-time' built into the programme, to allow them to get used to being on their own and managing this time well. Others wanted more activity and support, such as additional counsellor sessions, as they felt they were left on their own too much.

Summary of this inspection

Clients also fed back that due to the changes in both the programme and changes made due to the COVID-19 pandemic, communication wasn't always clear. For example, clients were able to have access to mobile phones due to lockdown and this was limited to the evenings and weekends, but some staff weren't always clear on when they should hand back phones. There was also a lack of clarity for the rules on use of communal areas and when they should be vacated and locked for the evening.

How we carried out this inspection

The inspection team comprised two CQC inspectors and a specialist advisor with a background in substance misuse.

During the inspection visit, the inspection team:

- visited the service and looked at the quality of the environment
- interviewed the registered manager, head of programmes and programme manager
- spoke with six members of staff, including two recovery workers, one medicines administrator, one finance manager, one maintenance manager and one estates worker
- spoke with five clients
- spoke with the pharmacist who dispenses medicines to the service
- reviewed seven client care and treatment records
- reviewed the clinic room and seven medication charts
- reviewed the service's incident reports over the past year
- looked at a range of policies and procedures related to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure Infection Prevention and Control (IPC) and cleaning audits are carried out to monitor quality.
- The service should ensure that the ligature risk assessment provides up to date mitigation to reflect changes from the refurbishment.
- The service should ensure the quality of the data allows managers to have oversight of training completion and when training is expired and needs refreshing.
- The service should ensure that risk management plans and care plans include information on harm reduction and clients have personalised early exit plans.
- The service should ensure that Blood Borne Virus (BBV) testing and sexual health checks resume with an alternative arrangement if nurses previously coming into the service are unable to.
- The service should consider updating their medication policy to exclude reference to opiate detox and withdrawal scales.

Summary of this inspection

- The service should ensure that changes made as a result of incidents are documented to inform what policies and protocols needed updating with a timeframe for completion.
- The service should prioritise the re-booking of appraisals for staff.
- The service should consider updating their deprivation of liberty policy to focus on the Mental Capacity Act as this is more applicable to the service type.
- The service should ensure that they communicate clearly to clients how they support their relatives and loved ones.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Residential substance misuse services

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

Are Residential substance misuse services safe?

Good

We rated safe as good.

Safe and clean care environments

The premises were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Cleanliness, infection control and hygiene

Staff followed infection control policy, including handwashing. There were various hand sanitiser points throughout the premises including the entrance to the service. The COVID-19 risk assessment included the cleaning of touch points and was reflected in the daily cleaning schedule. Cleaning records of the kitchen were logged by a laminated sheet to check tasks were complete and wiped clean each week. Infection Prevention Control (IPC) audits were still not taking place to identify if any improvements in cleaning were required and action could be taken accordingly.

The clinic room was clean, tidy and fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. It also had 24-hour CCTV installed which helped to mitigate any medication errors. Clients were informed this was in operation verbally however we asked for a sign to be put up outside the clinic room to further notify clients.

Environment and equipment

Fire equipment and alarms had been recently serviced and checked and there was a fire evacuation plan in place for clients and staff to follow.

There were no call alarms in the service. If clients needed to alert staff during the night, there was access to telephones located close to bedrooms and communal areas that dialled through to the sleep-in staff. Above each telephone there was instruction on how to call the staff member.

The ligature risk assessment identified where the potential ligature points were, what level they presented and mitigations to reduce risk. Potential risks were managed in part by the provider's exclusion criteria where clients with

complex mental health needs or who had attempted suicide in the previous six months or self-harm within the last three months were excluded. However, the ligature risk assessment stated that those at risk were to share a bedroom with another client, which places undue pressure on the client sharing with a client at risk. The service was converting all bedrooms to single occupancy, so this part of the risk assessment required updating.

Staff were trained on fire safety during induction and routinely conducted practice fire evacuations. A fire risk assessment commissioned by a fire safety specialist had recommended appointing fire wardens which the service had considered but felt it would not enhance the process as all staff members were competent in evacuation procedures.

The sharps bin had no date written on the label and a fire blanket in the first aid box was out of date. We also identified there was no room temperature monitoring in the bathroom where drug testing took place. The provider rectified this during the inspection by adding items to the clinic room audit checklist and obtaining a temperature monitor for the bathroom.

Equipment in the clinic room was re-purchased every three years instead of being recalibrated under manufacturer advice. There were stickers on each piece of equipment with a date to replace by.

Staffing

The service had enough staff, who knew the clients and received basic training to keep them safe from avoidable harm. Staff completed risk assessment and management plans with clients on admission and regularly reviewed them.

There were enough skilled staff to meet the needs of clients.

There were two vacant posts and the total vacancies were at 3.2%. Total permanent staff sickness was at 4.5% over the past 12 months. Vacancy data related to maintenance support and the recovery support team. Sickness calculation included four periods of compassionate leave and two occupational health referrals. The figures had no apparent impact to the service.

Managers supported staff who needed time off for ill health and actively supported them with occupational health referrals and adjusted work arrangements if applicable.

Staff covered annual leave and sickness for each other. The service did not use agency staff but had a pool of bank staff who were well known to the service to manage additional staffing needs.

The manager held a list of qualifications for each member of staff with staff holding qualifications relevant to their post.

Clients had regular one to one session with their recovery worker and counsellor. Clients said they were happy with the support they received.

Staff shared key information to keep clients safe when handing over their care to others. Staff used the daily morning meeting and a handover checklist to pass on need to know information.

Staff were on duty 24 hours a day, seven days a week with one duty staff member who slept on site to cover weekends, evenings and nights. A senior member of staff was “on call” at all times. There was a lone worker policy in place and a risk assessment with a procedure for staff actions should an incident occur. Sleep over shifts were covered by male staff.

The service recently installed a panic alarm system for staff which if activated gives email, phone and text messages to several senior staff.

All staff had Disclosure and Barring Service (DBS) checks or the relevant national criminal records checks appropriate for their country of origin. Staff awaiting DBS clearance did not work with clients unsupervised.

The service followed the exclusion criteria and did not take clients with known high-risk health conditions. The service's Medical Emergency policy listed examples of emergencies and what staff were expected to do. There was a qualified first aider on site 24 hours per day as all duty staff were trained in first aid. Staff would call 999 in the event of an emergency.

Mandatory training

Staff received mandatory training that included safeguarding adults, first aid, Mental Capacity Act, fire safety, Infection Prevention and Control, violence and aggression, health and safety, conflict resolution, equality and diversity and data protection. Staff involved with dispensing medications would also undertake care of medicines training.

In addition, each member of staff had a login for the Grey Matter Group, which provided access to eLearning on various topics. Where some in-person training was unavailable due to COVID-19 the provider had been using the modules on this platform to provide the basic level of training.

However, the training matrix was not clear on actual dates training had taken place or if a refresher had taken place. This meant that managers were not clear if staff had up to date training. We were assured training was being completed as managers received their completion certificates, but this was not reflected clearly in the training matrix.

Assessing and responding to client risk

Staff screened clients before admission and only accepted them if it was safe to do so. Referrers were required to complete a detailed application form and staff excluded referrals that were not suitable for the service, such as those with a recent history of self-harm or suicidal ideation or those requiring a medically monitored alcohol or opiate detox. They assessed and managed risks to clients and themselves well. In the event clients' physical and mental health were to suddenly deteriorate, staff would know how to respond.

Staff completed risk assessments for each client on arrival and reviewed this regularly and following an incident. We reviewed seven client care records. All seven care records had up to date risk assessments.

Electronic risk assessments followed a template which ensured key areas were covered and allowed leaders to ensure that this was completed and regularly reviewed during staff one to one sessions with clients. Following the initial lockdown due to the pandemic, the provider commissioned an external company who consolidated their risk assessments and approach to COVID-19 and provided scrutiny and recommendations related to this.

Staff knew about any risks to each client and acted to prevent or reduce risks. Any new or emerging risks were discussed in the daily morning meeting and reviewed again at the weekly multi-disciplinary team meeting.

The provider's statement of purpose included that if staff felt it necessary that they would search a client's room if items on the exclusion list were suspected. This would only happen with the client present and with their permission. The client welcome pack did not contain information to inform clients about this.

Good

Residential substance misuse services

Risk management plans and care plans did not include information on harm reduction and unexpected exit from treatment plans were not personalised.

Blood Borne Virus (BBV) testing had not routinely been offered due to difficulties accessing this during the COVID-19 pandemic. Previously this was taking place twice a month with nurses coming into the service to provide BBV testing and sexual health checks. The unknown status of BBV poses a risk of contamination which is further increased as there are no Infection Prevention and Control (IPC) audits taking place. Incident records showed three occasions whereby clients have had infected wounds logged this year. There was no evidence at the time of the inspection that alternative arrangements had been considered.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff understood how to protect clients from abuse and the service explained how they would work with other agencies to do so. The provider reported they rarely had to raise safeguarding alerts. In the last 12 months the Care Quality Commission received no safeguarding notifications relating to Yeldall Manor.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to date with their safeguarding training. However, online training had replaced face to face training due to COVID-19. The provider was looking to re-start face to face sessions when restrictions with their training provider allowed.

Staff were knowledgeable about safeguarding. Staff said they felt confident to raise issues with the senior management team and referral pathways to the local authority would be required.

If children were visiting the service, they would be supervised by a responsible adult.

Records

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records in relation to care records. However, the system for medications was producing errors in displaying data.

Client notes were comprehensive, up to date and all staff could access them easily. Staff stored client information electronically and in paper files. Risk assessment, care plans and medication information were stored on an electronic system. Counselling records were stored securely in paper files in the therapy team office. The therapy team kept paper copies of their notes securely, adhering to the British Association for Counselling and Psychotherapy standards.

The electronic system used for medication was showing discrepancies in the recording of certain information. For example, showing the incorrect number for administering medications, a medication was showing on the system to have been given twice when it was only given once. Managers told us it was difficult to reach the systems support team and were considering alternative options for an electronic system for medications.

Medicines

Good

Residential substance misuse services

The service used systems and processes to safely administer, record and store medicines. Staff would support clients to visit the GP to regularly review the effects of medications on client's physical health.

During our inspection we looked at seven medication charts. All seven charts were up to date with no gaps in recordings and any allergies were documented.

Staff followed an up to date medication policy. All staff identified to administer medicines were given this policy to read as part of their induction. Prior to undertaking any medicines administration, staff completed an online course followed by an in-house induction by the medicine administrator, with at least one observation. All staff had either received or were booked on to receive training. Staff competency was re-assessed during refresher sessions and was also highlighted to be re-visited after medication errors. However, oversight of medicine training competencies was challenging for managers to assess when training had taken place due to the format of the spreadsheet used for the training matrix (see governance section).

Staff stored and managed medicines and prescribing documents in line with the provider's policy. There was an up to date medicines stock list, no excess stock and all medicines were in date. The provider used an electronic system to capture and record medicines. The system notified staff and leaders of missed doses, or recorded gaps. As it was electronic it reduced the risk of written errors. Medicines practice was audited regularly and was effective in identifying medication errors.

During our inspection we reviewed daily temperature logs of the medicine's fridge and room temperature checks in the clinic room which were all within range. The clinic room had an alarm that would sound if it went above 25 degrees.

The provider had a good relationship with the GP's in-house pharmacy and would communicate regularly regarding prescribed medication. The pharmacist gave positive feedback and it was highlighted that staff were responsive in addressing any prescribing discrepancies. For example, a client was prescribed paracetamol of one tablet four times a day however it was noted by staff that the client's prior dose was two tablets four times a day and queried this with the GP who subsequently re-prescribed to the correct higher dose.

Clients would primarily book to see the GP to review their medication. To support staff at the service the clinic room had procedures displayed for mental health crisis, paracetamol and ibuprofen information, current client allergies, pharmacy abbreviations and advice on hypoglycaemia and diabetes.

Emergency medication was stocked including Naloxone. Naloxone is an emergency medicine used to treat an opioid overdose. Staff were trained to administer it or advise clients of its use and would give Naloxone to clients leaving the programme. We reviewed the phase one and two leaving checklist which showed Naloxone checks were documented to ensure all appropriate action was taken.

The service was no longer prescribing due to not offering opiate or alcohol detox. Clients attended the local GP practice for prescribed medication. However, the medication policy still included information about opiate detox and withdrawal scales despite being recently reviewed.

Staff told us clients would be given all their medication stock (up to one month's supply) in the event of unplanned or early exit to treatment. We reviewed the management of unplanned discharge and medications and there was no reference in policies for staff to consider documenting risk associated with this prior to clients leaving.

Good

Residential substance misuse services

The provider stocked homely remedies for clients. However, there was no protocol in the medication policy to reflect recent changes to homely remedy procedures following an incident that would now require two staff members to sign them in.

Incidents

The service had a good track record on safety and staff recognised incidents and reported them appropriately. The service managed client safety incidents well and managers investigated incidents appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

The service had an incident control and reporting policy in place and an electronic system to capture reported incidents.

Staff recorded accidents and incidents were noted in the handover notes. Any accidents and incidents related to medication were noted in the medication handover diary kept in the medications room. There was also an accident book to record accidents involving injury. There was an incident and control reporting policy in place.

Managers completed incident reviews on three accidents and one incident graded as serious and remedial action taken where necessary. Clients and staff were involved in the investigations. There had been no serious incidents reported to CQC over the past 12 months.

It was reported that the process for sharing lessons learnt to staff was via email. In reviewing governance meeting minutes it identified changes made as a result of the incident. For example, Ibuprofen was booked in at double the strength and homely remedies were now to be signed for by two staff and not one to mitigate this. But it did not clearly document what protocols or policies should be adapted to reflect the changes and a timeframe this would be completed by.

Are Residential substance misuse services effective?

Good

We rated effective as good.

Assessment of needs and planning of care

Staff completed comprehensive assessments prior to a client's admission to the service or soon after. They worked with clients to develop individual care plans and updated them as needed. We reviewed seven care and treatment records and found that all care plans reflected the assessed needs, were personalised and recovery oriented.

The admission team requested health and risk history information prior to admission and would not accept people with high health risks including epilepsy where fits are frequent and unstable mental health conditions.

Good

Residential substance misuse services

Clients were registered at the local GP practice. The GP practice carried out investigations and tests as needed and onward health referrals made. This was accessible throughout the client's stay.

Care plans included identified physical health needs and the service had good links with the local GP practice.

Evidence-based care and treatment

Staff provided a range of care and treatment interventions suitable for the client group, for example structured activities such as mechanic sessions, skills-based and therapeutic groups, one to one session with trained counsellors and one to one session with a named recovery worker to support daily living skills. Care plans included identified physical health needs and the service had good links with the local GP practice.

The service operates as a psychosocial rehabilitation centre focused on recovery.

Staff provided a range of care and treatment suitable for the clients in the service. This included a structured timetable with access to counselling sessions, key worker sessions, personal development and recreational activities. Throughout the pandemic the service re-structured the programme to ensure clients can engage in recovery support and other activities in the community in a safe way and have asked clients for their opinions.

The therapy team included British Association for Counselling and Psychotherapy registered counsellors. The Counselling Ethical Framework supported care in the therapeutic aspects of the programme. Clients had weekly one to one counselling sessions as well as group work however certain group activities had to be altered due to COVID-19.

At the last inspection, the counsellor and recovery worker were a dual role, but it is now two separate roles. Counsellors can solely focus on the therapeutic psychodynamic work with clients and recovery workers can build goals and objectives with clients.

Clients moving through all four phases at the service had opportunities for training, employment and housing. At the time of the inspection the service had started trialling food hygiene training and certificates for clients on phases one and two.

Clients also had access to the onsite gym, use of bicycles and were supported to get involved with specific hobbies and interests.

Prior to COVID-19 the service promoted mutual links and hosted groups that included 12-step fellowships such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA) and Al-Anon. Some of these have been adapted to ensure they are carried out safely. 12 step work features on the client timetable.

Where the programme had to be re-structured due to COVID-19, some clients felt communication was not always clear. Some clients said that they enjoy having more free time for personal development pursuits where others said they prefer more structure and organised sessions.

Client outcomes

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in some clinical audits and benchmarking and quality improvement initiatives.

The service used the Outcomes Star to better capture the client's voice, and outcome measuring against individual care plans. Staff are continuing to receive training in the Outcomes Star's use. The service is seeking to document more of how clients were consulted, and their choices valued within the care planning documentation. Staff and clients can then evaluate progress towards shared goals using the Outcomes Star.

The service used systems to collect data on their completion rates and report to the National Drug Treatment Monitoring System (NDTMS). Managers can look at retention and completion rates to see how people were progressing and why they were leaving early. Completion rates for the year to April 2021 (75%) were better than the previous year (60%).

Care plan reviews were taking place, but the process was not formalised. Discussions and feedback were not stored electronically to evidence occurring themes and how results were being used to make improvements.

There was evidence of medication audits taking place. Managers were able to review results and identify changes where needed.

Competent staff

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with informal supervision sessions. Appraisals were paused in the light of COVID-19. Managers provided an induction programme for new staff.

All staff were provided with an induction before commencing formal employment. Some training had been adapted in the light of the COVID-19 pandemic and online training courses have replaced face to face sessions. Records of an induction training checklist were stored in staff files and signed off by the line manager.

Managers supported staff in identifying training needs to develop their role. Counselling training was commencing in autumn 2021 for a further member of staff. The service offers a Foundations in Addictions Recovery course to staff however this had not been available since the start of the pandemic in March 2020. In November 2020, 11 members of staff also took part in the online Global Leadership Summit to develop leadership skills and focus on lessons learnt from the training and how they could apply this to the service.

The format of the training matrix made it difficult for managers to identify when training was completed or when refreshers had taken place. This was due to a complicated spreadsheet with various tabs and colour codes that were not easily understood by all managers. Where refresher training was due there was no date to identify if or when this took place.

Appraisals along with supervision were paused when the first lockdown came into play in March 2020. Line managers were asked to offer regular 'check-ins' with staff to monitor their wellbeing and support them with job tasks. Managers identified learning needs of staff via the informal check-ins. Staff told us that they had been well supported by managers. For check-ins, 97.2% of staff had these with their line manager regularly, this figure accounts for a staff member on furlough. Any staff on furlough were offered a monthly telephone call. Check-ins would be in the form of telephone, zoom or in person. For formal supervision, 77.8% of staff had restarted regular supervisions with their line manager however only 19.4% of staff have had an appraisal in the past 12 months. Appraisals were due to be re-booked.

The British Association for Counselling and Psychotherapy (BACP) Registered Counsellors met registration requirements and had individual external supervision and counselling group supervision with accredited supervisors throughout the pandemic. Individual supervision was carried out via zoom and group supervision initially on zoom and then in-person, adhering to government guidelines.

Quarterly all-staff meetings have not routinely been running throughout the pandemic, with the exception of one which took place in August 2020. Team meetings within departments increased and there was a daily zoom check-in/prayer meeting for staff working remotely.

Staff said they felt supported and could approach a manager should they need to discuss any issues or concerns. Staff had access to debrief sessions with the manager following an incident or difficult shift.

Multidisciplinary working

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team had effective working relationships with other relevant teams and with relevant services outside the organisation.

Staff held weekly multi-disciplinary team (MDT) meetings to review and discuss clients' care. We reviewed meeting minutes which showed there was consideration of client needs and appropriate support needed to improve client outcomes. However, there was no consistent framework for Multi-Disciplinary Team meeting minutes to ensure important agenda items were discussed and reviewed each week. In reviewing minutes over a three-week period there were different topics discussed each week. It stated that any actions from previous meetings were complete.

Staff attended a morning handover meeting to plan client care for the day and there was use of a handover checklist.

Staff were aware of how to refer clients for mental health input through community mental health teams however reported this was challenging in terms of referrals being accepted. Staff also knew how to access out of hours support for clients if needed.

Staff had contributed to the recent development of Public Health England (PHE) guidance for residential substance misuse services related to COVID-19 guidance. A group, including representation from staff and clients, was set up within the service to meet weekly to discuss COVID-19-related issues.

The provider had representation on the PHE residential rehabilitation working group and presented to the PHE homelessness working group on access to rehabilitation.

The service holds active membership of the Choices Group, a cooperation between substance misuse services for rehabilitation and detox providers. The group seeks to share learning and best practice from incidents, policy support, sharing of updates and ways to overcome funding challenges. They have recently been working with local commissioners on the development of local substance misuse pathways.

Clients are admitted from across the UK and staff liaised with local authorities and social service departments. Staff had good working relationships with local probation services when clients were admitted under Drug or Alcohol Rehabilitation requirements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Residential substance misuse services

Staff supported clients to make decisions on their care for themselves. The provider does not have a specific policy on the Mental Capacity Act 2015, there is a Deprivation of Liberty Safeguards (DoLS) but staff knew what to do if a client's capacity to make decisions about their care might be impaired.

The service had processes for seeking consent from clients prior to admission. The client information leaflets which are supplied, in addition to discussions with clients, are to further inform clients when they sign consent paperwork.

Staff discussed care decisions and some restrictions with clients, and consent was sought during treatment including COVID-19 restrictions.

Staff assessed capacity on admission and staff told us that clients who lacked capacity would not be admitted to the service. Staff said they would know what to do should someone's capacity change and used terms such as best interests' decisions.

Staff accessed training for the Mental Capacity Act (MCA) through the local authority however trainers have become unavailable due to being involved in the local authority's COVID-19 response team.

There was no specific policy for the Mental Capacity Act at the service. Staff were directed to a Deprivation of Liberty Safeguards (DoLS) policy that briefly made mention to the act but does not offer detail about the implications of the MCA. The DoLS policy does not reflect that it will continue to run alongside the Liberty Protection Safeguards (LPS) until next year.

Are Residential substance misuse services caring?

Good

We rated caring as good.

Compassionate care

Staff treated clients with compassion and kindness. They respected clients' privacy and dignity by being respectful of their personal space. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.

Clients told us the care they received was supportive and gave them opportunities to rebuild their lives. For example, clients were supported to contact loved ones they have lost touch with such as children.

Staff were respectful of clients' privacy and dignity, for example by knocking on the door and waiting before entering bedrooms.

Clients were made aware prior to admission that they would be expected to relinquish their mobile phones and would be stored away in the office for safe keeping. The provider in light of COVID-19 and travel restrictions decided clients could have access to mobile phones in the evening to be able to connect with family and friends. However, this change in procedure had not been reviewed and both clients and staff had mixed views on the value of accessing phones in the evening.

Good

Residential substance misuse services

When a new client arrived, they were allocated to another client as a 'shadow' during the initial weeks to ensure they settled into the environment and had the opportunity to ask questions about house rules and the programme timetable. Clients also met with their recovery worker and counsellor.

The provider recognised that the COVID-19 pandemic had impacted on the service's community feel. For example, staff and clients used to eat lunch together, with evening duty staff sharing dinner with clients too. This has not been able to continue throughout the pandemic and management acknowledged a sense of distance between staff and clients due to restrictions.

Understanding and involvement of clients

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Staff held morning meetings that clients could attend and there was a weekly clients-only meeting chaired by clients that could be used to feedback to staff.

The provider asked clients to complete feedback questionnaires by week four and at approximately 16 weeks into the programme.

Staff involved clients in care planning and risk assessment and sought their feedback on the quality of care provided. For example, clients are invited to be a part of the COVID-19 weekly groups that were developed during the pandemic. In re-structuring the programme due to COVID-19 managers said they involve clients to feedback on changes.

Clients were supported to complete an induction checklist on admission and received a handbook that included information on isolation period, house rules, orientation groups, the buddy system, and how to complain.

Some ex-clients were engaged with supporting clients to self-advocate and their details were displayed in communal areas.

Involvement of families and carers

Staff informed and involved families and carers appropriately however clients did not feel this was routinely offered and would like a dedicated support group hosted by the service.

Throughout the pandemic, the service maintained the involvement of clients' families and carers through recovery initiatives including joint key worker sessions, counselling sessions, and the impact letter exercise. Staff told us they informed and involved families and carers on an individual basis taking into consideration the client and their needs. For example, a counselling record showed involvement of a client's relative following an incident to promote recovery.

However, clients told us that support for relatives and loved ones wasn't routinely offered and needed to be sought proactively from the staff. Clients fed back that they would like more support for their relatives and loved ones. For example, by holding a befriending support group for relatives and loved one's.

Are Residential substance misuse services responsive?

Good

Residential substance misuse services

Good

We rated responsive as good.

Service delivery to meet the needs of local people

The design, layout, and furnishings of the premises supported clients' treatment, privacy and dignity. The service was undergoing refurbishment so that every bedroom would become single with en-suites. Clients could keep their personal belongings safe. There were quiet areas for privacy.

The provider was in the process of refurbishing twin bedrooms into single occupancy with en-suites.

Due to the nature of the building there was plenty of space for clients to convene in communal areas and separate rooms to provide space for group work or clients to have quiet time. There were extensive grounds outside available to clients and access to an onsite gym and bicycles.

Clients said that the food was of good quality but that they would like the opportunity to cook for themselves. For example, there was a microwave that clients on phase one and two were not allowed to use.

Meeting people's individual needs

The service is working to meet the needs of all clients, including those with a protected characteristic. The service works to a strict exclusion criterion and is limited to support clients with communication needs.

The service adhered to a clear exclusion criterion and all of the clients denied admission to the service over the previous 12 months had severe or complex mental health, behaviour difficulties or learning needs the service felt they could not support. Other reasons for exclusion included physical health needs that would make the service an unsuitable environment.

The building's structure meant that access for clients with physical disabilities was limited. The service did not accept clients whose physical disabilities would prevent them from accessing all parts of the building or engage in work-based activities.

The provider had an external report commissioned on the equality and diversity inclusion of the workforce and client population. It was concluded that while the workforce is diverse, additional work is required to ensure better representation of Black Asian and Minority Ethnic (BAME) clients in the community. Work to review the language and documents associated with the service was started to make the service more accessible to wider groups with the aim of improving access to its funded programmes.

Access and flow

The service was easy to access. The service accepted referrals from various routes, including self-referral. The service had a clear step-down pathway and clients were able to move from the residential treatment service to independent accommodation. The service had alternative care pathways and referral systems for people whose needs it could not meet.

Prior to admission clients were interviewed by the admission team who obtained pre-admission information related to the clients' previous physical health, mental health and forensic history, parole board reports, solicitor information and community mental health team involvement where applicable.

Admission information included a critical information sheet with personalised details such as important contact numbers. The admissions team followed the service's exclusion criteria and when admission was agreed, discussed provisional clients with members of the multi-disciplinary team.

The service offered a bursary scheme to financially support clients including clients from the homeless population, and staff took part in fundraising events for this. In last 12 months, clients have predominantly accessed the service through charity funded means as there was a significant reduction in local authority funded placements. The provider continued to work with commissioners to facilitate timely access to the service.

In the 12-month period of March 2020 to February 2021, 33 out of 44 clients completed the programme or transferred to on-going recovery support. The service communicated with the community service prior to clients' planned departure. Of the remaining 11 clients, one was recalled to prison, one involved a facilitated move, three chose to leave, and six were asked to leave by the service. Unless risk levels in the service were high for other clients, the service worked with clients, probation and other support structures in a time frame that ensured safe and appropriate moves were made.

The service had a step-down pathway that facilitated various stages for clients to initially stabilise and recover within a more structured programme, and then moved onto later stages if chosen by clients, to implement skills and promote independent living.

The service was part of the Choices Rehabs, a group of independent rehab centres where clients could be referred if the placement broke down or the service could not facilitate their referral.

Clients commented on the long wait between referral and admission. The provider reports to not make mention of wait times in policies due to the variance of external factors such as funding, parole hearings, prison release dates. On average, time from referral to admission is 104 days, the shortest was two days as it was a funded placement by the local authority with all necessary reports available immediately and the longest from referral to admission was 314 days because it was a complex client with criminal justice involved. The average time from referral to interview is 15 days where the admissions team support this process.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

There was a low level of complaints about the service. Over the last 12-month period there were three official complaints. Two were clients complaining about another client and this client requested a facilitated move which the provider supported. The other complaint involved a staff member and a client relating to food choices and a disagreement. The provider resolved this through a meeting where the staff member apologised directly to the client who accepted the apology.

Good

Residential substance misuse services

Complaints were on the agenda at each governance meeting which included participation by trustees. This meant that that any concerns would be raised at the next full board meeting. Any changes as a result of complaints were disseminated to staff through updated policies or procedures with relevant training if required. However, there is no centralised approach to documenting that learning had been shared with staff and clients.

The complaints procedure was contained within the client handbook given to each client on arrival, discussed at the initial orientation groups and copies were sent to family members on request. The complaints policy stated that there would be an acknowledgement of all complaints within 24 hours and a response within 14 days.

Are Residential substance misuse services well-led?

Good

We rated well-led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles, and had a good understanding of the services they managed. Managers were usually visible in the service but had been less so during the COVID-19 pandemic. They were approachable for clients and staff.

The registered manager and the head of programmes all had the relevant skills, qualifications and knowledge to provide positive leadership.

The registered manager was supporting the programme manager to develop their leadership skills to enhance the performance of the service. Coaching continues to be made available to other key staff to help develop their leadership skills or to assist with identified capability issues.

The programme lead and programme manager were involved in the daily operation of the service.

The provider reported that it was financially sustainable with adequate cash reserves despite the downward trajectory of local authority funding due to a focus on bursary provision by increased fundraising. The service was able to apply for a business interruption loan and used this to start converting the 25-bed service to 21-bed en-suite single rooms.

In the light of the COVID-19 pandemic, staff had worked more remotely since March 2020. Staff said leaders were less visible, but they were always contactable on the phone.

Pandemic restrictions had created some distance between staff and clients and the leadership team were looking to rebuild the sense of community.

Leadership oversight was sometimes compromised due to the documentation of cleaning, the training matrix and changes as a result of lessons learnt. It was evident systems and processes were being monitored by staff however improvements with documentation could be made so the service could provide clear evidence to its trustees about the quality of the service.

Good

Residential substance misuse services

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The service had a clear vision of men finding freedom from addiction to go on to live life to the full. The provider stated in its publicity and within the service that all staff and volunteers have a Christian faith and believe that the best means of achieving true freedom is through the relationship with God. However, the service's statement of purpose also says that it will never impose its viewpoint on anyone recognising freedom of choice in faith.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team.

The board of trustees included people with personal experience of addiction and recovery and the programme, a medical doctor, people trained in counselling and substance misuse work, people with business and charity leadership experience, and a family member of the founders.

Staff contributed to discussions about the strategy for their service, especially where changes had been made in the light of COVID-19 since last March 2020 and involvement of staff to participate in fundraising for bursary placements.

Culture

Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Staff felt the leadership and management of the facility encouraged an open, supportive and honest culture.

Staff attended equality and diversity training as part of their mandatory training. They said there were equal opportunities for all across the organisation.

Staff felt there was opportunity for development and career progression. The finance manager said that during their annual appraisal they had said they wanted to expand their role. They now gave budget training to clients and were also training an assistant to work alongside them. The provider was also offering a counselling course for a staff member to begin in autumn 2021.

Staff felt they could raise concerns without fear of retribution and if they did want to raise concerns would speak to a trustee.

The provider recognised staff success within the service through email to strengthen the service's philosophy of connection and togetherness.

The provider has supported staff with occupational health referrals during the pandemic. The provider put in place additional supports where needed and offered flexible working arrangements to help accommodate staff returning to work.

The service's sickness and attendance policy still does not make it clear how staff would access Occupational Health themselves to get support for their own physical and emotional needs without having to go to managers first.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively in the service and that performance and risk were managed well. However, the documentation of some governance approaches could be improved.

Care plan auditing was taking place and the service carried out weekly and monthly medicine audits. The provider used an electronic system to capture and record medicines. The system notified staff and leaders of missed doses, any record gaps and administering duplicated doses. Regular audits supported staff in reviewing medicine practice and improved ways of working.

Infection Prevention and Control (IPC) audits were not taking place. This posed a risk as no one was monitoring IPC standards in the prevention and spreading of infections and opportunities to improve IPC was lost.

Quality walkarounds did not take place to ensure oversight of quality within the service.

Quarterly governance meetings took place and we saw minutes that included actions/dates and named individuals. Quarterly board meetings also took place and discussed feedback received from clients. The registered manger also meets monthly with the chair of the board of trustees and addresses any significant issues such as complaints received.

We reviewed governance meeting minutes which showed standing agenda items including health and safety, risk assessments, complaints and concerns, incident reviews, audits, compliance, training, staffing and policy updates and developments. However, meeting frameworks still did not ensure standing agenda items such as safeguarding were routinely considered. Lessons learnt were also not a standing agenda item and where changes were identified as a result of an incident, documentation did not always record what protocols or policies would be updated.

The service had a data protection policy which contained sections on the data protection act principles and GDPR. The service offered data protection training to staff.

The provider routinely reviewed and updated their policies which documented a review date and author. The process for sharing policy and procedure updates is to email them to all staff highlighting the updates and asking them to familiarise themselves with the policy. In the case of key policies, confirmation that they have been read is gained by asking staff to sign a sheet attached to a paper copy of the relevant policy left in the registered manager's pigeonhole in the main office. The registered manager follows up with staff by email or in person until all have signed that they have read the relevant policy. However, some policies lacked key information or were not relevant to the service. The admission policy did not indicate an outline of potential wait times from referral to admission dependent on the client's circumstances. There was no stand-alone policy for the Mental Capacity Act (MCA). The provider held a Deprivation of Liberty Safeguards (DoLS) but would not admit clients who would be deprived of their liberty and the policy did not detail implications of the MCA.

In reviewing cleaning checklists, a laminated sheet was used which was wiped clean once the jobs have been checked. There was no paper or electronic version available for assurance purposes. The chef prior to going on furlough had kept

paper copies and the acting chef had not been informed of this therefore no paper copies had been completed. The fire risk assessment produced in 2018 had recommended actions commissioned from the fire safety specialist to implement a cleaning schedule to ensure the extract system was cleaned weekly and signed for. However, this cannot be monitored in the absence of kitchen cleaning records.

The provider was not reviewing its restrictive practices effectively. For example, clients were unable to lock their bedrooms, and this was not communicated in the client handbook or admission information. Restrictions on mobile phones and access to communal areas in the evening were not always clearly communicated with clients and staff which was causing frustration and confusion.

Managing risks, issues and performance

Staff had access to the information they needed to provide safe and effective care but were not always involved with inputting concerns into the risk register at an operational level. Where staff used information, they did this to good effect, for example, the COVID-19 working group.

Staff and clients were invited to be involved in the COVID-19 working group and had access to the live COVID-19 risk assessment document to review risks weekly during meetings. This enabled staff to be proactive in addressing concerns related to COVID-19 including testing.

Staff did not have access to or feed into the risk register at an operational level. In reviewing the risk register, it does not represent operational risk but was based on higher level organisation risk. For example, Blood Borne Virus (BBV) testing and issues with the medication electronic system were not on the register.

The provider is reliant on the Good Samaritan fund to be able to offer clients inpatient rehabilitation due to local authority cuts.

Managing information

Staff collected and analysed data about outcomes and performance

The provider used three systems to store information about staff and clients including the electronic system for clients and a combination of electronic and paper files for staff. Staff said they had no problems recording in three systems. However, where information was held on paper copies such as the induction training checklist, it relied on staff putting this data onto a spreadsheet. As no auditing of the training matrix happened this would be difficult to monitor.

The provider had recognised the limitations of the electronic system used for medication that accounted for 21 out of 33 recent medication errors through double recording of medication dispensed. The provider had started looking into other options for medication however this would mean an additional system for staff to use.

Staff had enough office space and information technology to do their work. Managers had their own offices to hold meetings and complete paperwork.

The provider was working on reviewing the data register as part of obtaining an information sharing agreement with the National Probation Service. This would enable them to obtain offender reports on potential clients more easily.

Engagement

Good

Residential substance misuse services

The service had engagement opportunities for staff and clients to provide feedback about the service

Staff and clients had access to up-to date information about the work of the provider via emails and meetings.

Clients had opportunities to give feedback on the service they received via client only meetings and client questionnaires and issues were fed back to the provider.

The results of client feedback questionnaires were collated by the registered manager to identify trends. The information was fed back to staff during the governance meeting.

Clients and staff met with members of the organisation's senior leadership team and trustees to give feedback.

There had not been clear communication to staff from management on clients' mobile phone use and access to communal areas which was causing frustration to both clients and staff.

Learning, continuous improvement and innovation

There was evidence of learning, improvements and innovation

The service had commenced refurbishment work to improve the quality of the service by making all bedroom's single occupancy with en-suites.

Where specific skills or experience were not available at board level or within leadership, the provider continued to seek outside support where necessary to improve the service. Over the pandemic period they had engaged support related to health & safety, human resources, financial management and trust fundraising.

The provider had got staff involved in the International Society of Substance Use Professionals (ISSUP) with staff having attended online training and the registered manager attending their new Quality in Treatment sessions earlier in the year to improve quality measures within the service.