West London Mission

The Haven

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as inadequate because:

- Clients living at the service were at risk of avoidable harm and did not always receive the care and treatment they needed. Despite the provider's attempts to improve, we found significant issues relating to the safety, effectiveness and leadership of the service.
- A clear model of care was not in place. Staff had not ensured they reviewed, assessed or responded to the changing needs of individual clients. For example, staff did not assess or manage risks such as falls, personal care or nutrition well.
- The service was not well led. Clear processes and procedures were not in place to ensure the service ran smoothly. Staff did not use audits effectively to identify issues and take action to rectify them in a timely way. The provider had faced delays in improving its information management system and the roll out of a new governance 'quality framework' for the service.
- Aspects of the environment were not well suited to client's individual needs.
- The team did not have easy access to the full range of specialists required to meet the needs of clients under their care. Staff had not coordinated client access to additional community services such as memory clinics and advocacy in the local area.
- Staff did not always plan and manage discharge well. Some clients had remained at the service when it was no longer suitable based on their individual needs. The service did not have a clear admission criteria in place.
- Staff had not developed holistic, recovery-oriented care plans informed by comprehensive assessments of clients' mental and physical health. Staff did not provide or ensure clients had access to a range of treatments they needed in line with national guidance about best practice around harm minimisation.
- Managers had not ensured the new staff team had access to adequate training to perform their role. Staff did not always work well together as a team.
- Staff treated clients with kindness but did not actively involve clients in decisions and the care planning process.

However:

- The service was clean.
- Despite challenges with the recruitment and retention of staff, the service ensured there were enough staff to support clients, using bank and agency staff where necessary.
- The provider had remained transparent and was cooperative in working with us to take enforcement action to rectify issues we identified.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Inadequate 	

Summary of findings

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Summary of this inspection

Background to The Haven

The Haven is an independent, residential substance misuse service provided by the charity 'West London Mission'. The Haven is dual registered with the CQC to provide the following regulated activities:

- accommodation for persons who require treatment for substance misuse
- accommodation for persons who require nursing or personal care

The service can provide accommodation for up to 26 male clients. At the time of the inspection there were 14 clients staying at the service.

This inspection was completed to check the progress of improvement and look at all areas of service quality to understand if the service was safe, effective, caring, responsive and well-led.

We last inspected this service in February 2021. At that inspection we found serious failures relating to the safety and leadership of the service. In response to these failures we took enforcement action and issued two warning notices telling the provider they must improve in several areas.

Since our last inspection, the service had faced many operational challenges which had undermined the rate of improvement within the service. For example, the provider had faced difficulties in recruiting and retaining a competent team to deliver the day to day support that clients needed. There had not been a full-time registered manager in post since February 2020. The provider had attempted to recruit to this post and had recruited agency service managers to oversee the service at different points.

Prior to our inspection, the provider indicated they were considering the closure of the service due to some of the operational challenges mentioned above. The provider also indicated that they were aware that the service no longer fitted within the organisational strategy and was not their area of expertise.

During this inspection we found a number of issues relating to the safety of the service and took urgent enforcement action. We issued a notice of decision to tell the provider we planned to cancel their registration. The provider accepted our decision and the service has now closed. Senior managers within the provider worked with the local authority and commissioners to ensure that all clients residing at the service found suitable placements to move onto.

What people who use the service say

Overall, the feedback we received from people staying at the service was positive. We spoke with five clients over the telephone who said staff were available to provide support when they needed it and were polite.

Clients said the service was comfortable and clean and they felt safe. Clients felt that staff treated them with kindness and respect, and they could ask for help when they needed it. Some clients had previously been homeless prior to their stay and the service had provided them with a place 'to call home'.

We also spoke to four relatives of clients staying at The Haven. We received mixed feedback from relatives and carers of clients. Some felt without the service their relative would have remained homeless and that the service had provided them with an invaluable alternative. Others felt that staff missed opportunities to engage with clients and did not meet all their needs including personal care.

Summary of this inspection

How we carried out this inspection

This inspection took place during the COVID-19 pandemic. To minimise the risk of infection to clients, staff and our inspection team, we adapted our approach. One inspector and a specialist advisor visited the site on 15 July 2021 for half a day to complete essential checks.

While on site we:

- toured the service
- reviewed paper records relating to eight clients
- checked the clinic room and medicine store
- interviewed an agency nurse
- spoke with managers

The remainder of our inspection activity was conducted off-site. As part of this we:

- spoke to five people using the service and four families. These phone calls were conducted by one of our Experts by Experience
- interviewed seven staff who were working or had recently worked in the service, this included bank and agency staff
- interviewed the service manager and their deputy
- interviewed one senior manager and the Chief Executive Officer of West London Mission
- looked at a range of policies, procedures and other documents relating to our concerns
- interviewed other external stakeholders involved in the care and treatment of clients.

Our final telephone interview was completed on 27 July 2021.

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

During our inspection we found many improvements the provider needed to make to comply with its legal obligations as a registered provider of care and treatment.

The service has now closed and all clients have been moved to new accommodation. We have also taken urgent enforcement action to cancel the providers registration with the CQC so it is no longer able to provide regulated activities.

We have included the below statements as an indicator of what we found during the inspection.

- The service must ensure that risks to the health and safety of individual clients receiving care are assessed and managed safely. Risk management plans must be in place for each client that address all risks identified. (Regulation 12(1)(2))
- The service must keep up-to-date care plans for each client to guide staff on how to meet client's physical and mental health care needs. Staff must also ensure each care plan is person-centred and clearly reflects the individual preferences of each client. (Regulation 12(1)(2))

Summary of this inspection

- The provider must ensure all safeguarding concerns are clearly recorded, monitored and appropriate action is taken to protect people from abuse when needed. (Regulation 12(1)(2))
- The service must ensure staff complete regular training and supervision to ensure they have the correct skills, competencies and experience to deliver care in a safe and consistent way, including the management of medication. (Regulations 18(1)(2); 12(1)(2))
- The provider must ensure that governance systems in place operate effectively so that leaders maintain full oversight of all areas of service quality and take action to rectify issues in a timely way. (Regulation 17(1)(2))
- The provider must ensure information management systems are in place to maintain accurate and complete records of each client including decisions made in relation to their care and treatment. These records should also be accessible to the relevant staff. (Regulation 17(1)(2))
- The provider must ensure policies and procedures are in place to provide staff with clear guidance on how to deliver specific aspects of the service safely and consistently. (Regulation 17(1)(2))
- The provider must seek and act on feedback from relevant persons about the service for the purposes of continually evaluating and improving service quality. This includes staff and clients. (Regulation 17(1)(2))

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Residential substance misuse services	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Inadequate

Residential substance misuse services

Safe	Inadequate
Effective	Inadequate
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

Are Residential substance misuse services safe?

Inadequate

Our rating of safe stayed the same. We rated it as inadequate.

Safe clean environment

The environment was clean, secure and staff followed good infection control procedures. However, some updates and maintenance work were required to improve safety within the service.

The service was secure. Members of the public could not gain access to the building without permission from staff. Clients had to request staff to open the entrance door for them. Closed-circuit television was in place in communal areas. The building was secure. Exit and entry to the service was through a locked door that staff would open and close for clients. Clients had fobs for their individual bedrooms and could access them at any time.

The building was clean. Staff made sure cleaning records were up-to-date. There were two members of housekeeping who completed general cleaning and helped residents with laundry. The provider had arranged for agency staff to attend the service daily, to carry out additional during the COVID-19 pandemic.

Staff followed safe infection control procedures. In response to the COVID-19 pandemic, the service had introduced regular testing for staff and clients and social distancing where possible. Staff wore suitable personal protective equipment. Changes in local and national guidelines had been monitored and communicated to staff.

Clients and staff could call for assistance using alarms that were fixed to the wall in communal areas and clients' bedrooms.

However, the environment required maintenance work and improvements to make it safer. The provider had instructed external consultants to undertake thorough risk assessments of health and safety and fire safety standards within the service. These assessments had highlighted building features that potentially compromised fire-safety and increased the risk of falls to clients. Although the provider had plans to address these issues, work had not yet taken place. For example, all fire safety doors within the service needed replacing, but this had not happened at the time of our inspection.

Clinic room and equipment

The physical layout of the clinic room required improvement. The provider was aware of this and had scheduled improvements to take place. The current clinic room had no handwashing facilities and limited space for physical health examinations.

Management of the clinic room was done by the agency nurses who worked in the service. They checked, maintained, and cleaned equipment within the clinic room.

However, permanent staff and managers did not retain clear oversight of the room. For example, some staff did not know where the keys were stored for the clinic room. The service manager and deputy were also unsure where one client's prescribed thickener was stored.

Staff had not managed the use of alternative spaces well. For example, the service had arranged for a local hospital to visit and complete blood-borne viruses (BBV) and liver function screening of clients. This had been done in a disused bedroom, but they had not removed the sharps bin after the screening. We pointed this out during our inspection and managers took action to remove the bin. This issue had not been picked up by the 'monthly manager's check' completed by the service manager.

Safe staffing

The service did not have enough staff who had been fully trained on each shift to meet clients' basic needs. The service employed support workers and project coordinators to deliver care and support.

Despite the recruitment drive undertaken by the provider since our last inspection, the vacancy and turnover rate within the service was still high. Out of the 15 posts involved with the delivery of care and support, eight were vacant. During our inspection, the service manager's post also became vacant. Managers had used agency and bank staff to fill any gaps and tried to only use agency staff who were familiar with the service.

The instability of the staff team delivering care and support led to inconsistencies in the delivery of care and support to clients. For example, some staff said they observed clients consuming their allocated levels of alcohol and would help them apply topical creams, others did not.

Since our last inspection the service had started to employ agency nursing staff to provide aspects of clients' care and treatment. This included the administration of medication, physical health monitoring and managing referrals for clients to external service including GPs, diabetic nurses and speech and language therapists. One agency nurse attended the service each day between 8am to 8pm.

Clients had sessions with their named key worker, but this was not well recorded and were not regular due to the turnover of staff.

Managers made sure all bank and agency staff had a full induction before starting their shift.

Mandatory training

Staff had completed some basic training to keep people safe from avoidable harm. This included first aid.

However, not all staff had completed their mandatory training; less than 65% of eligible staff had completed training for Safeguarding and Protection of Adults, Diabetes, Epilepsy. The low completion rate was partly attributed to the 'newness' of staff.

The service had plans to provide more face-to-face training but had not yet delivered it yet.

Assessing and managing risk to clients and staff

Staff did not safely assess and manage risks to clients well, potential exposing clients to avoidable harm.

The service did not have a clear admission policy or criteria in place and had prioritised other areas of improvement. Since March 2020, the service had not taken any new referrals due to the COVID-19 pandemic. Following our last inspection in Feb 2021, the provider had voluntarily extended this pause on admissions to allow them time to address issues within the service.

There was a significant gap in the information staff had access to about client's historic risks. This included initial risk assessments that had been completed for clients. This information had been stored on a database that the service now longer used. Current staff did not have access to this legacy system which meant information about clients' historic risks could not be reviewed.

Management of client risk

Since our last inspection the service had completed risk assessments and management plans for all clients. Staff had also completed a summary profile for each client which highlighted obvious risks to each client and provided some guidance on how staff should interact with each client. However, the service was still failing to ensure that staff assessed and managed all risks to clients.

We reviewed the care and treatment records for eight clients and found significant gaps in the way the service was managing individual client risks. Risk assessments were not completed using a standardised tool and the service was over reliant on the subjective judgment of staff completing risk assessments. Some potential risks went undetected or were 'played down'.

Where risks were identified, staff did not always put plans in place to manage them. Many individual client risks such as difficulties with swallowing, falls and mental health needs were not being assessed or well managed. For example, if clients were known to become 'aggressive' or agitated situations, risk management plans did not always detail how staff should respond to this behaviour or deescalate challenging situations safely. Staff had completed e-learning on positive behaviours management but had not applied this when completing risk management plans.

Staff were inconsistent in their approach to managing individual risks to clients. For example, it was unclear how staff decided how frequently clients needed observing throughout the day. This meant that some clients who may be at higher risk of falls were observed inconsistently throughout the day. Some staff also said they would observe clients consume their allocated alcohol for the day due to the possible risks of withdrawal, other staff said they did not and were unaware of the potential risks.

There were further inconsistencies as to how staff searched client's bedrooms and belongings to prevent them bringing alcohol or drugs into the service. Some staff said they checked client's belongings when they returned to the service, others did not. Housekeeping staff also completed searched of client's bedrooms, but the decision-making process behind the frequency of these searches was not recorded or clear when we spoke to staff. There was a lack of policy and guidance available to staff on how to manage these risks.

Staff did not make proactive plans to manage risks safely. They had not worked with clients to create safety plans if they found themselves in crisis.

Support staff had received first aid training and said they would call rapid response if they were concerns about a client's physical health.

Safeguarding

Since our last inspection there had been improvements in the way staff protected clients from abuse, but further work was needed. For example, the service had introduced new systems to help support clients to manage their finances in a safer way. However, in some client profiles there was still concerns relating to potential financial abuse of clients that had not yet been investigated by the provider.

Staff received training on how to recognise and report abuse that was appropriate for their role. Staff knew which other agencies to contact and work with to protect clients. For example, staff knew how to make a safeguarding referral and who to inform if they had concerns.

A safeguarding lead was in place who would take part in serious case reviews and make changes based on the outcomes, when needed.

Staff access to essential information

Staff did not keep detailed records of clients' care and treatment. Records were not clear, up-to-date and easily available to staff providing care.

Care records were not comprehensive, and staff sometimes faced difficulty accessing them. For example, when we asked new staff for copies of any assessments completed to decide the intake of alcohol for each client, staff were unable to locate these and were unsure when they had last been done. This meant clients may have been consuming unsafe or inappropriate levels of alcohol or cigarettes.

The service used a combination of electronic and paper records that was not well coordinated. This meant some pieces of information were not kept up-to-date.

The service had improved delivery of handovers and made changes after incidents to ensure information about clients was being shared. There were now handovers between every shift. Managers attended handovers and staff had improved the format.

Records were stored securely in a locked office.

Staff did share information they had about clients when handing over their care to others. Clients had hospital passports in place and agency nurses kept records on referrals they had made for clients.

Staff also shared information about clients and changes in their care at handover meetings. This was an improvement since our last inspection in February 2021. Some aspects of the handover required some improvement, for example there had been one incident where staff had thought one client had been missing when they were staying with relatives. Managers were continually working to improve the handover between shifts to ensure all staff were aware of important updates relating to each client. For example, shortly before our inspection managers made it routine practice to discuss all clients at handover as it was raised that some clients were not being discussed on a regular basis.

Medicines management

Medication management in the service required improvements to make sure clients received their medicines safely.

Since our last inspection the provider had arranged for an agency nurse to attend the service daily from 8am to 8pm. This was to provide clinical input to the service after we raised concerns about the way medication was being managed at our inspection in February 2021. Apart from these agency nurses, no other staff had been trained by the provider to manage medicines. This meant that when an agency nurse was not onsite there was no one that had been trained to safely administer or support clients with their medication.

Some support workers reported that they administered medication such as topical creams. This should not have been happening as they had not yet completed training with the service and be signed off as competent.

In addition, training had not been given to all relevant staff on how to prepare drinks using a thickener that had been prescribed for clients at risk of choking. When we raised this with the service manager, they were unaware of where the thickener was stored. This put people at increased risk of harm.

The service had not yet relaunched its medication policy and this was in draft format at the time of our inspection.

Staff did not ensure that clients' medicines and physical health were regularly reviewed. Staff were unable to confirm when some clients had last received a medication review or annual physical health check from their GP. Staff believed the agency nurses were responsible for organising client's physical health and medication reviews with the GP but were unsure when or if this had been done.

However, since our last inspection there had been a decrease in the number of medication errors within the service. The clinic room had been kept clean and tidy and medicines were stored correctly.

At the time of our inspection there were no controlled drugs on site that required additional secure storage.

Reporting incidents and learning from when things go wrong

Compared to our previous inspection, incidents were now managed in a safer way. Where staff reported incidents, managers investigated them, and shared lessons learned with the team.

The service had refreshed its incident reporting policy, which now included a flow chart to guide staff through the process. This was explained to staff during their induction.

Managers debriefed and supported staff and clients after any serious incidents. Managers investigated incidents. Clients and their families were informed of these investigations where applicable.

Inadequate

Residential substance misuse services

Staff received feedback following the investigation of an incident and acted on the findings.

The provider made notifications to external bodies as needed including the CQC. This was an improvement from our findings in February when some incidents had not been raised.

Are Residential substance misuse services effective?

Inadequate

Our rating of effective went down. We rated it as inadequate.

Assessment of needs and planning of care

Staff had not assessed the full range of clients' needs well. They had not developed comprehensive care plans for each client.

We reviewed eight clients care records and found gaps in all aspects of care planning and assessment. This meant clients mental and physical health needs were not always met. For example, some client profiles mentioned they needed assistance with personal care but there were no written care plans or exact guidance available to staff on how to do this.

Staff had made attempts to make care plans more personalised and holistic. For example, there were now written 'summaries' of all clients that indicated their immediate needs, dislikes and likes. However, these were subjective and based on the comments of individual staff and were not underpinned by a clear, evidence-based assessment. For example, in one client's care plan the use of alcohol was suggested to reduce aggressive behaviour, but it did not state the amount and when this intervention should be considered.

Clients had their physical health reviewed but this was not well recorded. The agency nursing staff completed base-line physical health monitoring for clients where needed. This included blood sugar monitoring and blood pressure. The provider had also arranged a local hospital to come in an provide screening for blood-borne viruses (BBV) and liver health. Outside of the agency nurses, other staff were not always aware of how client's physical health needs were being assessed and managed.

Best practice in treatment and care

The service had not embedded a clear model of care. Some staff described the service as a care home for people who drank alcohol. Other staff told us the service aimed to support people with alcohol recovery and rehabilitation. In the past the service had operated as a 'wet hostel' based on a harm-minimisation strategy. This allowed clients to drink agreed amounts of low strength alcohol.

However, we found that the service had not implement best practice based on national guidance available for harm minimisation and substance misuse services. For example, we found there were no clear processes or procedures in place to ensure the amount of alcohol consumed by individual clients was assessed and managed safely. Staff had not received training in alcohol withdrawal and substance misuse awareness. Staff were unable to locate the last assessment completed with clients to ensure the level of alcohol they were consuming was safe and that they had considered any possible interactions with individual client's medication, risk of falls and other factors.

Inadequate

Residential substance misuse services

The care and support provided no longer meet the full range of needs of clients. The service had failed to develop its service provision to meet the changing needs of service users. For example, some clients no longer consumed alcohol and had developed further cognitive impairments, staff had not responded to these changing needs and adapted the way they planned, delivered and supported these clients.

Staff did not always co-ordinate client's access to wider services when needed. Clients did not have easy access to the full range of care and treatment options based on national guidance. For example, clients with mental health needs did not always have access to mental health support services that may have benefited them. The new staff team had not referred clients to local services such as counselling.

Clients did not always have access to good physical health care as required. Staff had ensured all clients were now registered with the local GP practice. However, staff had not ensured each client had accessed a physical health care check from the GP or a medication review. Since our last inspection the service had supported clients to access support from Occupational therapist and Speech and Language therapy.

Staff did not meet client's dietary needs and assess those needing specialist care with nutrition and hydration well. In two care plans we reviewed staff had recorded that clients had 'possible dysphagia,' (problems with swallowing), but staff had not investigated this risk any further. Staff had not taken action to further investigate the needs of clients who may have benefited from specific nutritional advice or the use of screening tools, such as the Malnutrition Universal Screening Tool (MUST).

Staff did not support clients well to encourage them to take part in programmes to help them live healthier, more independent lives. The service had engaged with a local drug and alcohol service, but staff reported client uptake had been low, with only one client who had accessed the service and reduced their drinking. There were no plans in place to show how staff were attempting to encourage and motivate other clients to access this service. Staff did not support clients to carry out daily tasks to maintain their own independence or revisit these skills as part of their recovery. For example, no clients had been supported to self-administer their medication or cook their own meals where possible. Clients were not referred to smoking cessation clinics at the GP surgery.

Staff did not use any recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes.

Staff did not take part in regular audits, benchmarking and quality improvement initiatives to evaluate the effectiveness of the service they provided. Since our inspection in February 2021 the new service manager had introduced some audits to consider service provision such as catering and had made improvements in these areas. However, the provider had failed to ensure a full programme of audits was carried out. At our inspection in 2019, staff had been completing monthly client summary audits, care plan audits, risk assessment reviews, which the manager reviewed and made changes on based on the result, but at this inspection we found that these audits were no longer in place.

Skilled staff to deliver care

Managers did not ensure all staff delivering care had the right skills and experience to meet the needs of the clients. Some staff had no experience of substance misuse services and did not have access to specific training on the subject. Where staff did have skills in this area from previous roles, the lack of clear policy and guidance within the service meant that people used their own initiative and knowledge. This led to inconsistencies in the way care and treatment was delivered.

Responsibilities were sometimes given to staff who did not have the knowledge or experience to complete them. For example, care plans and risk assessments had been written and reviewed by staff who did not demonstrate a good understanding of care planning or risk management principles.

Some specialist training required to meet the needs of clients was not yet available to staff. For example, the provider did not offer training in relapse prevention, harm reduction, assertiveness and counselling. At our inspection in 2019, staff had been able to access additional training, but were no longer able to. The provider said it had completed a review of training needs and was relaunching a training programme as part of wider organisational changes. Managers said that following this training programme refresh there would be opportunities for staff to develop their skills and knowledge, but this had not happened yet.

However, managers did ensure staff including agency and bank staff, completed an induction before starting work. This was an improvement since our last inspection.

Managers had not yet completed appraisals with staff due to the length of time they had been employed. Managers had completed some supervisions with staff.

The provider had also paid a psychologist to attend the service to facilitate reflective sessions fortnightly. Team meetings had been introduced and managers ensured staff could attend them and passed on information to those who could not.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

There were sometimes gaps in clients' care caused by lack of external services and by the way staff worked with one another within the service.

The service had struggled to recruit a full team of permanent project coordinators and support workers, which meant it was reliant on bank and agency staff to fill gaps. Care was not well coordinated between the permanent staff team and agency staff. This had led to inconsistencies in the delivery of care and support. For example, outside of the agency nursing staff, the wider team, including the service manager, were not always aware of what progress had been made in arranging appointments for clients with external services including GPs, blood tests, dental care and neurology appointment, as this was done by the agency nurses.

Staff did not always work well with external services required to meet client's needs. Assessments we reviewed during the inspection did not always include input from the GP, community mental health teams and other required specialists. In addition, some clients did not have an identified care coordinator (this would usually be a social worker within a local authority). Staff did not always know the contact details of care coordinators that had been allocated to individual clients. This meant regular care reviews did not happen for all clients.

However, if clients had been admitted to an hospital and would require more intensive support upon discharge, the service contacted social services to arrange a placement review. Agency nurses had also started to connect with speech and language therapists and occupational therapists. Although this was not always well recorded.

Adherence to the Mental Health Act

Inadequate

Residential substance misuse services

The service did not have oversight of community treatment orders that some clients were subject to under the Mental Health Act. Although the service did not detain patients under The Act, staff should have been able to access copies of clients' community treatment orders and been aware of any relevant conditions. Staff could not access these records and did not always know the status of relevant clients under the Mental Health Act.

Staff did not demonstrate clear knowledge or have access to advice regarding the Mental Health Act and its Code of Practice. Instead they relied on client's individual social workers and care coordinators if they had one.

Care plans did not include information about after-care services available for those clients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

During this inspection there were five clients who had a Deprivation of Liberty Safeguard (DoLS) in place or were awaiting assessment for one. Staff monitored the progress of these applications.

Staff had received training in the Mental Capacity Act but did not always show a good understanding of what mental capacity meant. For example, some staff did not understand the principles of best interest decisions or how capacity might fluctuate for people under the influence of alcohol. The overall training compliance rate for Mental Capacity Act and Deprivation of Liberty Safeguards was 70%.

Staff did not always record clients consent when they made decisions about their own care and treatment. Sometimes staff did not consider assessing capacity in relation to specific decisions made by clients. In particular, staff should have considered completing capacity assessments when supporting clients to make a decision who also had cognitive impairments or were diagnosed with Korsakoff's syndrome, (a type of dementia commonly caused by chronic alcohol abuse).

There was a lack of specific guidance for staff on supporting clients subject to the Mental Capacity Act and Deprivation of Liberty Safeguards. The service did not monitor or complete specific audits about how well it followed the Mental Capacity Act.

When clients had been assessed as not having capacity by social services, staff did not always record best interest decisions or have access to capacity assessments. The service had failed to record or did not know about some clients' individual history and had not had active conversations with clients about advance care planning where appropriate.

Clients did not have easy access to information about independent mental health advocacy and staff did not routinely support clients to access this service.

Are Residential substance misuse services caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Clients said staff behaved kindly towards them. During interviews, staff spoke about clients in a care way and during our onsite visit we observed caring interactions. Most carers, families and health care professionals felt staff did their best to support clients and were genuinely interested in their welfare.

Despite their best efforts, staff did not deliver care in a person-centred way. For example, some care plans did not provide specific guidance as to how staff members should support the client's personal care needs. This potentially exposed them to support that was not safe.

The provider had not yet implemented updated policies and procedures about protecting client confidentiality. The provider had drafted a 'data Management and Information Security' but this was not yet available to staff. Staff had not yet completed specific training in maintaining client confidentiality. Although we found no incidents where client confidentiality had been breached, the service had not yet taken enough action to avoid this.

Staff did not always direct clients to other services and support them to access those services if they needed help. For example, the service had not ensured some clients with mental health needs had access to appropriate support. Some clients who required more advanced nursing care had not been assessed in a timely way and moved onto appropriate services. Following the inspection, the provider confirmed placement reviews for all clients were taking place.

However, staff felt able to raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients. However, some staff also said they were unclear who lead the shift and that the current management arrangement for the site was sometimes confusing, meaning potential concerns may have been missed. These factors meant some issues may not have always been fed to senior managers and could have put clients at risk of harm.

The provider took steps to promote client welfare. For example, they funded the purchase of clothes and toiletries when needed. They also took steps to ensure clients could access ongoing support after their discharge.

Involvement in care

The new staff team had not yet developed a clear and consistent approach to involving clients and their families in the planning and delivery of care and support. This meant there were missed opportunities to involve people in their care and deliver a person-centred service.

Involvement of clients

Clients were not always supported to be involved in the planning and assessment of their care and needs. We found examples where staff made attempts to involve clients in the planning of their care, but further work and training was needed. Some care plans we reviewed still included generic statements like 'to remain compliant with my medication', when describing a client's individual goal.

We reviewed the care plans for eight clients and found that these had not been completed in collaboration with service users. When we asked staff about service user involvement, they stated some clients had chosen not to engage with the process, this was not well recorded in assessments.

Staff did not always consider clients' individual communication needs that may have limited their involvement in their care. Staff had not explored alternative ways to communicate with people with cognitive impairments caused by dementia, mental health needs and those with learning disabilities.

Inadequate

Residential substance misuse services

Staff had not clearly worked with clients to find ways to maintain their independence. There were no activities offered to clients to help them revisit or maintain basic living skills for example cooking, self-medication or pursing personal interests in the local community.

The service did not have clear systems in place to ensure clients could routinely access advocacy and make advance decisions about their care. Some clients were subject to deprivation of liberty under the Mental Capacity Act 2005 or had been placed at the service as a condition of their community treatment order under the Mental Health Act 1983. there was no routine approach taken to ensure these clients and others had access to advocacy. An independent advocate had visited the service, but staff were unclear about how this had been arranged and when the service would refer people to this service.

Clients could give feedback on the service and their treatment and staff supported them to do this. Regular community meetings were held for all clients and a client feedback box was available for clients to post feedback.

Involvement of families and carers

Family and carer involvement in client care and support was varied. Care plans we reviewed did not include input from family members or carers of clients.

The provider had not yet embedded a structured approach to actively involve families in the care planning process and overcome these external factors. This meant there had been missed opportunities for this to happen.

Sometimes family or carer involvement was limited due to factors that were outside the service's control. For example, some clients did not have carers or family members who wished to be involved in their care and support. Other clients had family that were based far away from the service. The COVID-19 pandemic had also prevented visitors from coming on site. Most families felt staff had contacted them to inform them of any changes to client care.

We spoke to the families of four clients staying at the service. Feedback we received about the quality of care delivered at the service was mixed. Some family and carers feedback that they did not feel involved in the care and support received and that the service had not listened to their suggestions in relation to individual client's support options.

Families and carers said they were able to give feedback on the service, but this was done informally. The new staff team had not yet developed a clear approach as to how it would capture carer feedback and incorporate this into the development of the service.

Are Residential substance misuse services responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

Access and discharge

Access to the service was not well managed and had not been prioritised as an area of redevelopment. The service did not have a clear admission criteria in place at the time of our inspection.

Inadequate

Residential substance misuse services

The service had voluntarily halted all new admissions to the service since March 2020. The provider originally made this decision in response to the COVID-19 pandemic. Following our February 2021 inspection, senior managers had agreed to not admit new clients until issues within the service had been addressed through their restructure programme.

Information about current client admissions to the service was not available this included original admission dates and pre-admission assessments. Staff stated these records were held on a legacy database they did not have access.

The service was not discharge-oriented and had been considered as a 'home for life' for clients for some time. Clients had been residing at the service for many years. Some clients' needs had changed during this time and the provider could no longer meet these needs.

At the time of our inspection the senior management team were arranging placement reviews for several clients and showed a clear commitment to supporting clients to find new placements at more suitable services.

Although the discharge planning process was not clearly defined, the provider had supported some clients to move when they had posed obvious risks to the safety of other residents or themselves. Staff were able to give examples of how they had supported two previous residents to find more appropriate services in the past.

Facilities that promote comfort, dignity and privacy

Some aspects of the design and layout of the service environment were not therapeutic or recovery-orientated.

The main communal lounge was based on the ground floor and had a pool table, television and other activities available such as books and games. Aside from this space, there were limited spaces in use for clients to use in their day to day living. The service had plans to reinvigorate a separate activities room and second lounge but had not yet started this work.

The clinic room on the ground floor was small and did not have handwashing facilities.

Some bedrooms had kitchenettes in them, in which clients had previously been able to make their own refreshments. However, the provider had disconnected the hobs in these kitchenettes due to potential fire risks.

Some aspects of the service environment were not accessible to clients with mobility needs or those at risk of falls. Access to the garden was down a steep flight of steps or a long sloping path. Inside the building there were not enough handrails available for clients. The service was aware of some of these environmental issues but had not yet made improvements.

Minimal adaptations had been made to make the environment dementia friendly, despite current some clients living with the condition. Senior managers were aware of the need to make the service more dementia friendly if they continued to provide care with clients with the condition.

Despite some issues with the suitability of the environment, each client had their own bedroom with an ensuite bathroom. Bathrooms had 'step free' access making them accessible for people with mobility needs. Clients could personalise their bedrooms if they wanted to. Managers said they had plans to work with each client to improve the overall aesthetic appeal of the environment and make it more meaningful to them.

There was a room where clients could meet with visitors in private. Clients could also make phone calls in private. There was also a designated smoking lounge where clients could smoke.

Clients' engagement with the wider community

Further work was needed to support client engagement with their local communities.

Staff did not yet have a clear approach of how they would encourage and motivate clients to actively reconnect with their communities and pursue their interests. Since our last inspection the service had introduced a new programme of activities, which were available seven days a week. However, participation in these activities was not always recorded and on the day of our inspection these activities were not taking place. Staff said they were working with residents to find meaningful activities based on their individual interests to improve their engagement, but this had not yet happened.

The service had offered clients access to a local service that offered support around drug and alcohol, but only one client had successfully engaged with these services.

Staff had not routinely considered clients' wider needs such as housing, education and employment, family, faith, legal, and financial support as part of the care planning process.

Staff had supported clients to stay in contact with families and carers and encouraged them to develop and maintain relationships with others in the service. Regular community meetings were held, and clients were encouraged to join.

Meeting the needs of all people who use the service

The service did not always meet the full range of needs of all clients.

Staff were not always proactive in responding to or assessing the individual communication needs of clients, some of whom had learning difficulties, cognitive impairments or spoke other languages. For example, information leaflets and care plans were not available in easy-read format or other languages when clients may have benefited from this. When we raised this with the service manager, they said they would make these resources available if requested by clients,

The service provided a variety of food to meet the dietary and cultural needs of individual clients. Freshly cooked food was served daily out of a well-equipped kitchen. Since our last inspection the service manager had worked with the kitchen team to improve the choice of food available, offering more options to meet the specific needs and preferences of service users. They had also introduced catering audits as a way of monitoring client experience at mealtimes and the overall quality of food.

The provider had ensured clients had access to spiritual and religious support. Staff recorded these needs in client care plans where applicable.

Listening to and learning from concerns and complaints

The provider had received no formal complaints in the twelve months leading up to this inspection.

However, there were gaps in the way the service reported, handled, managed and responded to complaints and concerns.

Inadequate

Residential substance misuse services

The provider was in the process of reviewing and relaunching its complaints and feedback policy. The mandatory training assigned to staff at service level did not include specific training on handling complaints and concerns.

Clients, relatives and carers said they would raise concerns with staff directly if needed but were not aware of the formal complaints policy. No clients we spoke with indicated they had wish to make a complaint in the last twelve months and said if they had concerns, they would tell staff.

Managers said they would investigate complaints if brought to their attention.

Are Residential substance misuse services well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders at service level did not have the specialist knowledge and experience required to manage the day to day running of the service safely. They did not always demonstrate good understanding of the services they managed.

A senior management team had been overseeing and visiting the service on a regular basis. This included two area managers and the provider's deputy chief executive officer.

However, there were still significant gaps in leadership capacity at service level. Since our last inspection, a new deputy and service manager had been recruited to help run the service. Neither had experience in delivering support for people with substance misuse needs. During this inspection, the service manager, who had started their application to become the new registered manager, left the service. Following our inspection, the provider made further attempts to find an interim manager to help manage the closure of the service but was unable to find one.

Managers did not always provide clear guidance to staff. At our last inspection, some staff reported the approaches of different managers had sometimes led to miscommunication regarding the delivery of clients' care and treatment. This had not improved. During this inspection, staff described unclear management of the service and the local decision-making process. For example, staff were sometimes unclear on which manager to contact or listen to when making decisions about the daily running of the service. Some described service level leadership as chaotic.

Despite the above issues the senior management team helped run the on-call manager support line for the service and encouraged staff in the service to contact them whenever needed.

Vision and strategy

The provider's senior leadership team did not have a clear vision for the service and lacked clarity around the model of care in place. External stakeholders and staff providing care were unclear as to what the service was aiming to provide. Some described it as a care home, while others described it as a substance misuse service. As described in our findings under effective, the service was not achieving clear outcomes of harm minimisation.

Inadequate

Residential substance misuse services

Prior to the inspection, the provider told us that they were considering the closure of the service. During the inspection, we discussed this decision with senior leaders who explained the service did not fit with their future organisational strategy and that the current service would require further transformation that was not possible to do whilst open. The senior leadership team had evaluated their ability to provide a quality service and by the end of this inspection process had officially announced their plans to close the service.

Culture

Staff felt respected and were motivated to deliver a good service but did not have effective support or the right systems in place to do this.

All staff we spoke to said they were trying to do their best for the people that used the service. However, they noted that, due to the high turnover of staff, there had not been sufficient time to build a strong team-dynamic at service level. Communication within the service was sometimes disjointed.

Relationships between staff were not always positive and the lack of clear leadership at service level inhibited an open working culture. All staff we spoke to said they were trying to do their best for the people that used the service but reported some conflicts between managers.

The lack of clarity around local level leadership meant staff did not always know where to go for support.

Staff felt able to raise concerns in relation to individual clients but did not always raise concerns about the way the service was managed with leaders. During the 12 months prior to our inspection, whistle blowers had reported concerns to us about the service. When we had shared this information with the service, they took action to investigate and respond to these concerns. A whistleblowing procedure was in place at the time of the inspection and formed part of the staff induction.

The provider had not yet implemented systems and resources to ensure staff had access to opportunities for development and career progression. At the time of our inspection, many staff within the service were still in their probationary period or completing their induction.

Senior managers were keen to grow staff and client engagement to collect feedback and build strong team relationships, but they were at the start of this journey when we inspected. The provider had arranged weekly staff reflections group, facilitated by an external psychologist for staff to raise their concerns.

Staff had involved clients in some decisions about changes to the service and recognised there were further opportunities to do so. Since our last visit the menu of the food had been redesigned to better suit the individual preferences of people using the service. Senior managers had also taken time to discuss potential changes with clients and staff but had not actively involved them in the decision-making process.

During our inspection, senior managers discussed that they wished to involve clients more with the redesign of the service and recruitment of future staff but had not yet had time to embed these changes.

The provider had taken steps to promote equality and diversity within the service. Staff had access to equality and diversity training. Clients were supported to celebrate religious festivals and national holidays where possible. Managers recognised that this was an area of work that needed further development.

Staff had access to support for their emotional health needs through an employee assistance programme.

Staff, clients and carers had access to up-to-date information about the work of the provider and the services they used, for example, through the bulletins, newsletters and so on.

Governance

Despite the provider's best efforts, our findings from the other key questions demonstrated that governance processes did not operate effectively at service level. Although managers had more oversight of the day to day running of the service since our last inspection, performance and risk were still not well managed. This meant the service did not run smoothly.

Audits had been introduced but did not cover all aspects of service quality. For example, some audits had still not yet taken place to assess the quality of specific areas, such as care planning and record keeping. Issues we found with the quality of care planning had not been identified by the team. Some of these issues, such as inadequate risk assessments put clients and staff at increased risk of harm.

Policies and procedures had not been developed or implemented in time to ensure that the service provided safe, effective care. Since our last inspection, the provider had been working on the development and roll out of a set of new policies and procedures. However, there were still gaps in specific policy and guidance needed to deliver the service. For example, there was not set process or policy in place to guide staff on how to support clients who required more frequent observations due their individual risks.

However, since our last inspection there had been some improvements in governance. For example, managers now met on a regular basis to discuss the service and these minutes were recorded. Team meetings with staff delivering care and support had also taken place to discuss updates and learning from incidents. Key issues and updates were also fed from service level to the provider’s board of trustees.

Management of risk, issues and performance

The service did not always implement action plans robustly and did not ensure that improvements were maintained.

For example, at our last inspection we found the lack of clear care planning processes in place had led lead to individual client needs not being identified or managed safely. Following the February inspection, the provider had reviewed all care plans and attempted to embed a new care planning process. At this inspection we found these changes had not rectified the issue. Although care plans had been reviewed and the format updated, they still did not identify or address client needs, as detailed in our findings under safe and effective above.

Some improvements the provider had made needed time to embed. For example, the provider had paid for external consultants to redesign the information management system in place but there had been delays in implementing some of these changes. This meant staff still did not have access to the information they needed to deliver safe client care. The service manager and area manager had also visited other local services to identify good practice but had not yet embedded changes following these visits.

Staff did not use quality improvement methods or engage in improvement activities at service level. Improvements made within the service were often in reaction to issues raised.

The provider had an overall risk register which included the service.

The service had contingency plans in place for emergencies for example, adverse weather or a flu outbreak.

Information management

The service did not manage information relating to the care and treatment of clients well. At our last inspection in February 2021, it was not easy for staff to maintain high quality client records, due to limitations with the information management system in place. During this inspection, we found similar issues.

Senior managers had committed to the update the information system, but changes, including the roll out of new care planning tools, had not yet been implemented. At this inspection, we found staff still did not have access to the information they needed to provide safe and effective care.

Staff did not collect and analyse data to gauge the overall performance of the service. For example, managers did not regularly review or have easy access to dashboards summarising key performance indicators (KPIs) relating to the performance of the service. This included information such as retention and sickness rates, mandatory training and results of quality audits.

The provider made notifications to external bodies as needed including the CQC. This was an improvement from our findings in February when a number of incidents had not been raised.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not ensure risks to the health and safety of individual clients receiving care were assessed and managed safely. Risk management plans were not in place for each client that address all risks identified. • The service did not keep up-to-date care plans for each client to guide staff on how to meet client's physical and mental health care needs. Staff did not ensure each care plan was person-centred and clearly reflected the individual preferences of individual clients. • The provider did not ensure all safeguarding concerns were clearly recorded, monitored and that appropriate action was taken to protect people from abuse when needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not ensure that governance systems in place operated effectively. Leaders did not maintain full oversight of all areas of service quality and take action to rectify issues in a timely way. • The provider did not ensure adequate information management systems were in place to maintain accurate and complete records of each client, including decisions made in relation to their care and treatment. • The provider did not ensure policies and procedures were in place to provide staff with clear guidance on how to deliver specific aspects of the service safely and consistently.

This section is primarily information for the provider

Requirement notices

- The provider did not seek and act on feedback from relevant persons about the service for the purposes of continually evaluating and improving service quality. This included staff and clients.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service did not ensure staff complete or have access tot he necessary training and supervision to ensure they had the correct skills, competencies and experience to deliver care safely. This including the management of medication.

Inactive