Ocean Recovery and Wellness Centre Ltd

Ocean Recovery and Wellness Centre

Inspection report

94 Queens Promenade
Blackpool
FY2 9NS
Tel: 01253595628
www.oceanrecoverycentre.com

Date of inspection visit: 28 September 2021
Date of publication: 17/11/2021

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?	Requires Improvement
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

We rated the service as good because:

- The service building was safe and clean, and staff adhered to infection control procedures.
- There were enough skilled and experienced staff to ensure that care and treatment was delivered in a safe way. Staff received regular clinical supervision and an annual appraisal. Staff knew how to report incidents, were trained in safeguarding vulnerable adults and knew how to handle complaints.
- All clients were risk assessed and staff had created risk management plans to mitigate any risks identified.
- Clients told us staff were kind, caring and supportive towards them. Clients were involved in decisions about their care and treatment.
- The service adhered to the Mental Capacity Act and a doctor within the service carried out capacity assessments when needed.
- Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

However:

- Staff were not up to date with all aspects of their mandatory training. Areas of low compliance rates included equality and diversity, fire training, first aid awareness, health and safety, environmental risk assessment, automated external defibrillator and cardiopulmonary resuscitation, moving and handling theory , basic life support and record keeping.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Ocean Recovery and Wellness Centre

Ocean Recovery and Wellness Centre provides 24-hour care for clients who are undergoing detoxification from alcohol or substance misuse. The service is based in Blackpool. It has 14 bedrooms, all of which were single occupancy at the time of this latest inspection due to Covid-19 restrictions. The service accepts nationwide referrals from males and females aged 18 years or older. The service accepts referrals for clients who are privately funded. The service was registered with the Care Quality Commission in December 2014 to carry out the following regulated activities:

- Accommodation for persons who require treatment for substance misuse and,
- Treatment of disease, disorder or injury.

There is a registered manager in place and the service has support from a sessional doctor who attends the service when there are new admissions. There is a nurse onsite seven days a week from 9am to 5pm.

The service was last inspected on 25 September 2017 and no regulatory breaches were identified.

This latest inspection was a comprehensive inspection for which we have rated the service. Our findings are outlined in this report.

How we carried out this inspection

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Our inspection team comprised two Care Quality Commission inspectors. During the inspection visit, the inspection team:

- spoke with the registered manager of the service
- spoke with all seven patients who were using the service and two carers
- spoke with the service's nurse, a locum doctor, two recovery workers and the recovery lead
- spoke with the service's chef

Summary of this inspection

- looked at five clients' care records
- looked at the service's medicines management arrangements
- looked at the quality of the service environment and observed how staff were caring for clients
- looked at documents relating 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 MUST take to improve:

- The provider must ensure that staff are compliant with all aspects of their mandatory training and any other training which relates to the safe running of the service.

Regulation 18 (2) (a)

Action the service SHOULD take to improve:

- The provider should consider the use of additional recognised treatment outcome measures.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Residential substance misuse services

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

Are Residential substance misuse services safe?

Requires Improvement

We rated it as requires improvement.

We identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to low compliance with mandatory training and as such, this means there is a rating limiter of requires improvement for safe (see below for details).

Safe and clean care environments

All areas of the service were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the service layout

Staff completed and updated risk assessments of all the service areas. All bedrooms within the service were assessed for ligature risks. Clients with suicidal ideation or who self-harmed were placed in bedrooms on the ground floor which were closer to the staff room and, therefore, could be reached more quickly if needed. The service's main environmental risk assessment was updated on an annual basis as a minimum or sooner if audits had identified any risks. Staff also carried out regular safety checks including weekly boiler checks, weekly temperature checks and outdoor environmental checks.

The service complied with guidance on same sex accommodation. There were three bedrooms within the service which shared a bathroom which were each allocated to clients of the same gender to maintain their dignity. However, female clients were usually given en-suite rooms, so they did not have to cross the corridors where male clients were based.

Staff had easy access to alarms and clients had alarm systems in their bedrooms.

Maintenance, cleanliness and infection control

The service areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. We spoke with all seven clients who were using the service and they spoke highly of the domestic staff and said they worked hard to keep the service clean.

Staff followed infection control policy, including handwashing. The service had adapted its cleaning regime to reduce the risk of the transmission of Covid-19. Domestic staff cleaned the service regularly and touch points within the service were cleaned three times a day. The service had extended the cleaning times on Fridays so that a deep-clean of the service could take place every week.

To comply with Covid-19 guidance, staff ensured visitors to the service took a lateral flow test that day, had their temperatures checked and were provided with a fresh face covering before being able to access the premises. Hand sanitising gel was available throughout the service for people to use.

Clinic room and equipment

The service's clinic room was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. It contained a blood pressure machine, scales and other physical health monitoring equipment. Resuscitation equipment was available and had been subject to regular recorded checks and maintenance. Staff received training in the use of the equipment as part of their automatic emergency defibrillator and cardiopulmonary resuscitation training.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had enough nursing and medical staff, who knew the clients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep clients safe. These included:

- One whole-time equivalent service manager
- 1.3 whole-time equivalent nurses
- Five whole-time equivalent recovery workers
- Nine whole-time equivalent support workers

One of the nurses was contracted to work 10am to 4pm at weekends but they were flexible with their time; worked additional shifts when necessary and also delivered an acupuncture session every Thursday morning.

There was a sessional doctor and a locum doctor who attended the service to carry out assessments for new admissions; deal with any concerns about mental capacity or attend the service in an emergency. There were also three housekeepers and two chefs within the service.

Disclosure and Barring Service checks were in place for staff carrying out care and treatment at the service.

The service had low vacancy rates. These included a whole time equivalent support worker, a whole time equivalent maintenance person, a whole time equivalent administrator and a 0.72 whole time equivalent head of housekeeping.

The service had a high turnover rate. However, the service was small and although only five staff members had left over the last year, this equated to an average of 18% turnover. One staff member had retired, one left to run their own business, one returned to community work, one resigned and another left due to significant health issues.

All vacancies, including those as a result of staff turnover, were being recruited to and the provider anticipated they would be filled within the next four to eight weeks.

The service had low rates of bank and agency staff. Only one bank member of staff had been used in the last 12 months and they had been recruited as a permanent staff member.

There were cover arrangements for sickness, leave and vacant posts, which ensured client safety. Cover was normally arranged by staff within the service. The service's establishment figures for recovery workers was four whole time equivalent but there were five in post, so they could cover staff absences.

Managers supported staff who needed time off for ill health. Staff we spoke with said the service manager was very supportive and encouraged them to attend medical appointments or take time off to undergo medical procedures when needed.

The average staff sickness rate over the last 12 months was 9.6% and this was mainly in relation to long term health conditions. Over 70% of staff had taken no sickness absence at all during the past year.

Managers accurately calculated and reviewed the numbers and grade of nurses and support/recovery workers for each shift.

The service manager could adjust staffing levels according to the needs of the clients.

Staff shared key information to keep clients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the service quickly in an emergency. The service's nurse worked from 8am to 4pm Monday to Friday. A doctor was on-call and contactable by telephone 24 hours a day, seven days a week. The doctor was able to attend the service quickly if there was a medical emergency. Staff also supported clients to attend a local walk-in centre for any urgent medical needs. We spoke with a locum doctor who told us they completed the Royal College of Physicians training and were appraised by a medical officer. The locum doctor provided evidence of any completed training and appraisals to the manager of the service.

Mandatory training

The mandatory training programme was comprehensive and was designed to meet the needs of clients and staff.

However, staff were not up to date with all aspects of their mandatory training. The overall compliance rate for mandatory training was 74% and the shortfalls in compliance were in relation to training modules fundamental to safe practice and dealing with emergency situations.

Compliance figures which were particularly low included:

- Fire Training (70.59%)
- First aid awareness (64.2%)
- Health and safety (47%)
- Basic life support (51.7%)

- Environmental risk assessment (21.05%)
- Automated external defibrillator and cardiopulmonary resuscitation (64.29%)
- Moving and handling theory (21.05%)
- Record keeping (42%)
- Equality and diversity (57.1%)

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well.

Assessment of client risk

Staff completed risk assessments for all clients on admission to the service. Staff carried out a priority risk assessment for all clients on admission which was followed by a comprehensive risk assessment within 48 hours of admission using in-house risk assessment tools.

The risk assessments covered current substance misuse, prescribed medication, detox history, physical health, mental health, risk of suicide and self-harm and vulnerable adults and children. The regularity of how often risk assessments were reviewed was dependent on the risks identified. We looked at five care records and found all were up to date.

Staff were able to recognise and respond to warning signs and deterioration in clients' health. Examples of warning signs and possible deterioration in health given by staff included breathlessness, unclear speech, shaking, lack of eye contact, lack of appetite and non-attendance of client group sessions.

There were systems in place to ensure clients suffering from withdrawal symptoms were seen as a priority. The service's doctor assessed clients due to undergo a detox programme and put a regime in place including anti-sickness tablets, pain killers and advice around diet and 'when required' medicine. All clients were placed on 15-minute observations for the first 24-hours of admission, hourly observations for the next 24-hours and then every four hours for the duration of their detox. Staff used the Clinical Institute Withdrawal Assessment for Alcohol tool which is used for the assessment and management of alcohol withdrawal. In severe cases, staff sought medical advice to help clients.

Management of client risk

Staff knew about any risks to each client and acted to prevent or reduce risks.

When appropriate, staff created and made good use of risk management plans.

Clients were made aware of the risks of continued substance misuse and harm minimisation. Safety planning was an integral part of recovery plans.

Staff identified and responded to changing risks to, or posed by, clients.

The provider had a policy and procedure in place for emergencies relating to withdrawal and detoxification such as seizures and overdoses.

Staff knew what the service's protocols were in relation to clients who unexpectedly exited from treatment. These included encouraging clients to stay, investigating what needed to be in place at the client's home to keep them safe, alerting the client's next of kin, and, if necessary, liaising with the police or community substance misuse services. Clients who were also issued with information letters when they unexpectedly exited their treatment which gave contact details of mutual aid groups, carers support groups and details of the service's aftercare service.

Use of restrictive interventions

There was a list of banned items within the service. These included caffeine, alcohol and drugs that were not prescribed, knives and other sharps although razor blades were allowed if the client's risk assessment identified no associated risks. There had been instances in which clients who wore flip-flops had slipped or fallen so a decision was made not to allow these to be worn to reduce the risk of injuries in the future.

Clients agreed not to form intimate relationships with each other, leave the service on their own unless it was for a medical appointment or wear clothing which was offensive or advertised drugs, alcohol or caffeinated drinks as part of their care and treatment contract.

The provider had a policy in relation to dealing with behaviours that challenge. Staff used talk-down and tone of voice as de-escalation techniques when clients' behaviours became heightened. If a client's behaviour became unmanageable, staff called the police for assistance.

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 received training on how to recognise and report abuse, appropriate for their role. Examples of the possible signs of abuse given by staff included unexplained bruising, financial problems and changes in mood and presentation.

Staff kept up-to-date with their safeguarding training. All staff had completed their safeguarding vulnerable adults training which was mandatory.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, the service had not made any safeguarding referrals in the 12 months prior to our inspection.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received training in equality and diversity, the provider had equality and diversity policies and staff regularly engaged and received feedback from clients about how they were feeling.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

The service manager told us that children did not visit the service.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Good

Residential substance misuse services

The service's care records system was paper-based. Client's care records were comprehensive, and all staff could access them easily. Records were stored securely in locked cabinets.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. There were medicine administration record sheets for each client which were completed correctly. We reviewed prescription charts for all seven clients using the service and they were all in order. Stocks checks were in place for medicines and were completed. There were checks for medicine allergies, monitoring the effects of medicines on physical health, and monitoring drug interactions and urea electrolyte and liver functions. We saw evidence that prescriptions of 'when required' medicines were reviewed. We also saw evidence that there was guidance, assessments and authorisation forms in place in relation to the use of homely remedies.

Cupboards for drugs, including controlled drugs and fridges were in order and complied with national guidance. Medicines were transported and disposed of by an external pharmacy service. The provider had a policy on controlled drugs and the controlled drugs register was clear and up to date. There was a controlled drugs register in place which was up to date. There were full audits of meds completed which included controlled drugs and stock balance. Appropriate storage facilities were in place. Medicines management was overseen by nurse.

The service has a naloxone champion in place and all staff had received training in the use of naloxone.

Clients who used the service did not use prescribed substitute medicines. Any regular medicines were reconciled by the service's doctor on admission and dispensed by staff members. The service's doctor also prescribed medicines to help clients undergoing a detox who were suffering from withdrawal symptoms.

Chlordiazepoxide and Oxazepam were the two primary medications being used in relation to detoxification and withdrawal.

The service had stocks of emergency medicines such as naloxone and for the treatment of anaphylaxis.

Track record on safety

The service had a good track record on safety.

The provider reported there was one serious incident within the service in the last 12 months which was in relation to a fall on to steps outside the service building.

The service manager told us that there had been no adverse events within the service in the last 12 months.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them 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.

Good

Residential substance misuse services

Staff knew what incidents to report and how to report them. Incidents that occurred within the service included falls, incidents of aggressive behaviour and medicines errors. Staff who spoke with us said that the number of incidents within the service were low.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

There had been no never events in the service.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong. A staff member told us about a medicine administration error in which the client concerned was given a full explanation and apology. An incident form was completed for the error and the matter was addressed by the service manager. The client did not wish to take the matter any further and suffered no harm as a result of the error.

Staff who spoke with us said the service manager debriefed and supported staff after serious incidents had happened and incidents were discussed in daily meetings or with individual members of staff if they were of a sensitive nature.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations if the client had given their consent for them to do so.

There was evidence that changes had been made as a result of feedback. For example, there had been instances in which clients who wore flip-flops had slipped or fallen so a decision was made not to allow these to be worn to reduce the risk of injuries in the future.

Are Residential substance misuse services effective?

Good

We rated effective as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all clients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected clients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive assessment of each client's drug and alcohol dependency within 48 hours of admission which formed part of a comprehensive risk assessment. We looked at five care records and saw evidence these assessments had been completed. They also included an assessment of the client's physical health.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. Each client had a recovery plan in place that was completed on admission with the client's involvement and reviewed every two weeks. Recovery plans contained an overview and history of the client and identified the client's goals and what was required to meet them.

We saw evidence in clients' care records that staff regularly reviewed and updated care plans when clients' needs changed.

Care plans were personalised, holistic and recovery-orientated.

Best practice in treatment and care

Staff provided a range of treatment and care for clients based on national guidance and best practice. They ensured that clients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the clients in the service. These included cognitive behaviour therapy, mindfulness and trauma counselling.

Staff delivered care in line with best practice and national guidance. Policies and procedures including the monitoring of side effects were in place.

Staff identified clients' physical health needs and recorded them in their care plans. Staff made sure clients had access to physical health care, including specialists as required. Clients whose condition was stable were able to attend medical appointments with their own specialists. Staff registered clients who had only recently been admitted to the service with a local surgery. Staff monitored clients' blood pressure, pulse and monitored the blood sugar levels of clients with diabetes and care planned to address any physical health needs accordingly.

The service had sought advice from an advanced practitioner in relation to the effect the cessation of alcohol and increase in food intake had on blood sugars for clients with diabetes. An instruction sheet was prepared explaining the basics of diabetes; how to identify low blood sugar and what actions to take in relation to this.

Staff met clients' dietary needs. The service had its own in-house chef who could cook meals to take individual needs into account. The service's nurse did weekly or fortnightly health and nutrition assessments of clients.

Staff helped clients live healthier lives by supporting them to take part in activity programmes or giving advice. Staff took clients out each day on walks in the local community. Staff had run a project on the benefits of health and wellbeing to aid recovery which included advice about stress, nutrition and exercise.

Staff assessed how clients were feeling and the effect of care and treatment outcomes. Staff used mood diaries twice-daily to monitor clients and also sought feedback from clients. Staff also used the recognised Clinical Institute Withdrawal Assessment for Alcohol tool. One staff member said they used the recovery star, though other staff seemed unaware of its use within the service. The recovery star is a recognised tool used to measure treatment outcomes for people with drug and alcohol addictions.

We saw evidence in are records that staff regularly reviewed care and recovery plans with clients.

In the 12 months prior to our inspection, 92% of clients who used the service had successfully completed their treatment.

Staff used technology to support clients. The service provided clients with tablets and clients could bring their own laptops into the service. These could be used to access online therapies and to stay in contact with family members and friends.

Staff took part in clinical audits and quality improvement initiatives. These included audits of clients' risk assessments, medication administration sheets, safeguarding referrals, accidents and incidents, exit surveys, complaints, health and safety inspections, hygiene and data protection.

Skilled staff to deliver care

The service team included or had access to the full range of specialists required to meet the needs of clients using the service. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the clients using the service. These included a nurse, a doctor, recovery workers and support workers within the service. Other specialists such as GPs and other primary medical services could be accessed in the local community.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. Induction included policies and procedures, familiarisation with the service and how it operated, fire safety, filing systems, mandatory training, social care and the Clinical Institute Withdrawal Assessment for Alcohol tool which is used for the assessment and management of alcohol withdrawal.

Staff knew how to complete observations and were knowledgeable about detoxification, withdrawal symptoms, how to monitor clients' health in the escalation processes if there were concerns. We saw evidence of staff having referred clients to a doctor as a precautionary measure when there were concerns about their health.

Managers supported staff to develop through yearly, constructive appraisals of their work and via regular, constructive clinical supervision of their work. The provider's targets were six supervision sessions per year and one annual appraisal. The compliance rate for clinical supervision was 94% and the rate for appraisal was 89%.

Managers made sure staff attended regular team meetings or gave information to those that could not attend. The service manager met with staff every day and discussed incidents, safeguarding, complaints, clinical updates, staffing issues, Covid-19, catering, housekeeping, maintenance, environmental issues and administration issues.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Examples of specialist training undertaken by staff within the service included the use of naloxone and epi-pens, personal appliance testing, a level three diploma in health and social care and the drug and alcohol national occupational standards.

Managers recognised poor performance, could identify the reasons and dealt with these. The provider had a performance management system in place which included a process for addressing staff performance issues.

Managers recruited, trained and supported volunteers to work with clients in the service.

Good

Residential substance misuse services

Multi-disciplinary and interagency teamwork

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 service team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff made sure they shared clear information about clients and any changes in their care, including during daily handover meetings.

The service's teams had effective working relationships with other teams both within the organisation and externally. The service had good relationships with external safeguarding teams and attended multi agency risk assessment conferences to discuss high risk cases to ensure clients were adequately safeguarded. The service also had a good relationship with a local mental health service from which they could obtain advice about the Mental Capacity Act.

There was evidence of liaison with GPs within clients' care records. Clients had given their consent to share information that included GPs.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for clients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. The compliance rate for mandatory Mental Capacity Act training was 85.7% and only two new starters were yet to complete this training.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary. There had been no deprivations of liberty safeguards applications made in the 12 months prior to our inspection.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. The service's doctor could provide advice and guidance and the doctor carried out capacity assessments if needed. The service also had links with an external mental health service and could make referrals to this service if required.

Staff gave clients all possible support to make specific decisions for themselves before deciding a client did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a client needed to make an important decision.

When staff assessed clients as not having capacity, they made decisions in the best interest of clients and considered the client's wishes, feelings, culture and history.

Are Residential substance misuse services caring?

Good

Residential substance misuse services

Good

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They respected clients' privacy and dignity. They understood the individual needs of clients and supported clients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for clients. We spoke with all seven clients who were using the service as part of a group and they told us they had been overwhelmed by the kindness and experience of staff within the service. Clients said staff made them feel welcomed; respected their privacy, knew who they were and treated them as individuals and were understanding.

Staff gave clients help, emotional support and advice when they needed it. One client said they had experienced a bad day the week before and two members of staff checked on them regularly to ensure they were ok. Another said they had spoken to a staff member about their concerns for another client's health and the staff member was brilliant in their response to the client's needs. A client said staff had been very supportive after they suffered a bereavement.

Staff supported clients to understand and manage their own care treatment or condition. Clients said the transformation in people from admission to now was amazing.

Staff directed clients to other services and supported them to access those services if they needed help. On discharge from the service, clients were given contact details of mutual aid groups, carers support groups and details of the provider's aftercare service.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards clients.

Staff followed policy to keep client information confidential. Staff received confidentiality training and other training such as assessing needs and care planning also highlighted the need to maintain client confidentiality.

Involvement in care

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 independent advocates.

Involvement of clients

Staff introduced clients to the service as part of their admission.

Staff involved clients and gave them access to their care planning and risk assessments. Clients told us they were involved in the development of their recovery plans and we saw evidence that risk assessments were devised based on conversations with clients.

Good

Residential substance misuse services

Staff made sure clients understood their care and treatment and found ways to communicate with clients who had communication difficulties.

Staff involved clients in decisions about the service, but because some clients' treatment only lasted for 28 days, this was not always possible. Clients were able to make suggestions about what the group sessions within the service should cover.

Clients could give feedback on the service and their treatment and staff supported them to do this. There were weekly meetings within the service where clients could speak to staff about ideas and suggestions about their care and treatment. Clients could use comments cards to give feedback and the provider also had a complaints procedure.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We spoke with two carers whose loved ones had or were using the service. They told us staff supported and informed them about their loved one's progress.

Clients were asked to provide a code word on admission, and this was given to any family members or carers the client wished to speak with.

Staff helped families to give feedback on the service. There was a complaints process although neither of the carers we spoke with had ever had a need to make a complaint.

Carers and family members were able to write to the service to give feedback.

Staff gave carers information on how to find the carer's assessment.

Are Residential substance misuse services responsive?

Good

We rated responsive as good.

Access and discharge

Staff managed beds well. A bed was available when needed. Discharge was rarely delayed for other than clinical reasons.

The service had robust alternative care pathways and referral systems in place for people whose needs could not be met by the service or who were unable to comply with specific treatment requirements. These included mutual aid groups, community substance misuse services and primary medical services.

The service had clearly documented admission criteria with open access to any adult with drug and alcohol problems. Clients went under a pre-admission screening, so the service was aware of their specific needs. Clients tended to access the service within 24 hours of the pre-admission assessment.

Managers and staff worked to make sure they did not discharge clients before they were ready.

Staff did not move or discharge clients at night or very early in the morning. Staff assessed the needs of the client who was leaving the service and arranged for a taxi to pick them up and booked trains if required.

Discharge and transfers of care

The service had low numbers of delayed discharges in the past year. There were only two occasions in the past year where discharge was delayed. Both occasions were in relation to housing issues as the clients were unable to return to their home address.

Staff carefully planned clients' discharge and worked with care managers and coordinators to make sure this went well. For clients undergoing a detox programme, discussions around discharge planning did not take place until the detox had been completed and they had moved to the recovery part of their care and treatment journey.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the service supported clients' treatment, privacy and dignity. Each client had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and clients could make hot drinks and snacks at any time.

Each client had their own bedroom, which they could personalise.

Clients had a secure place to store personal possessions. Bedrooms had lockable wardrobes, so clients' possessions were secure.

Staff used a full range of rooms and equipment to support treatment and care. Each client had their own bedroom, there was a fully equipped clinic room, kitchen and dining area, communal lounge, outdoor space which clients could easily access and a room for group sessions which included a large screen television with internet access.

The service had quiet areas where clients could meet with visitors or make phone calls in private.

Clients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. Clients said that the food was very good, and the chef was very accommodating to their needs and requests.

Clients' engagement with the wider community

Staff supported clients with activities outside the service, such as work, education and family relationships.

Staff supported clients in accessing opportunities for education and work. The group sessions included exercises which were educational and helped clients have a better chance of gaining employment in the future. These sessions were also used to remind clients of the importance of maintaining support networks such as family members, carers and friends.

Staff encouraged clients to participate in group activities to help with their recovery. We observed a session in which clients were asked to write letters to say goodbye to their addiction and were given the option to read the letter in front of their peers. Clients found this emotional and cathartic and the staff member running the group was supportive and encouraging to all attendees.

When clients were discharged, staff provided them with information about the provider's after care service and contact details for mutual aid groups and community substance misuse services.

Staff encouraged clients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all clients – including those with a protected characteristic. Staff helped clients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service provided bedrooms on the ground floor for clients with mobility issues and a stair lift was installed within the service building.

Staff made sure clients could access information on treatment, local services, their rights and how to complain.

The service was able to provide information leaflets available in different languages when needed. Staff were able to use online translation services to produce information in different languages on request.

Clients could access the service within 24 hours. There were no waiting lists or issues in relation to the care and treatment of high-risk clients.

Managers made sure staff and clients could get help from interpreters or signers when needed.

Clients had access to spiritual, religious and cultural support. The service ran meditation classes for clients and staff also helped clients to access churches and mosques in the community.

Listening to and learning from concerns and complaints

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

Clients and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in client areas.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and clients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. There had been two formal complaints in the previous 12 months, and both related to the dissatisfaction of the care and treatment received. Lessons learned from the complaints were shared with staff and included the need to ensure documentation was clear and permission was obtained from clients to speak with their family members or carers.

Good

Residential substance misuse services

Staff protected clients who raised concerns or complaints from discrimination and harassment. The service manager said they had needed to conduct a mediation session between two clients who were in conflict with each other. This was successful and the two clients went on to become friends. There were also equality and diversity policies and procedures in place to protect clients and staff members.

Clients received feedback from managers after the investigation into their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. Letters from clients and family members praising the service were shared with staff and placed on noticeboards.

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. They had a good understanding of the services they managed and were visible in the service and approachable for clients and staff.

Leaders provided clinical leadership. The service manager did regular checks of care records for all clients currently using the service and fed back her findings in order to promote best practice. They also provided advice to staff on how to encourage clients to participate in group activities when they were reluctant to do so and provided updates on issues around medicines management. The service's nurse had provided guidance to staff on the use of naloxone ampoules.

Leaders had the skills, knowledge and experience to perform their roles. For example, the service manager had worked in substance misuse settings for 27 years and the recovery lead had worked in substance misuse for 10 years.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for clients and staff.

Vision and strategy

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

The service's values were 'respect, endurance, holistic, action and brave'. Staff knew and understood the vision and values of the team and organisation and what their role was in achieving them.

All staff within the service had a job description.

Staff had the opportunity to contribute to discussions about the strategy for their service during team meetings and discussions in supervision and appraisal sessions.

Staff could explain how they were working to deliver high quality care within the budgets available.

Good

Residential substance misuse services

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff felt respected, supported and valued. They felt proud, positive, satisfied, valued and part of the organisation's future direction. Managers monitored staff morale, job satisfaction and sense of empowerment.

The provider recognised staff success within the service. Two clients had recently written letters to say what the service had done for them and what it meant for them. These letters were read out to staff by the service manager to demonstrate to staff how their work made a difference to the lives of the people they cared for.

Staff appraisals included conversations about career development and how it could be supported.

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff said the service manager was very supportive and encouraged them to attend medical appointments or take time off to undergo medical procedures when needed.

The provider had a whistle blowing policy in place that was accessible to all staff.

Staff felt able to raise concerns without fear of retribution.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The provider had equality and diversity policies and procedures and the service's admission criteria meant that any adult with substance misuse problems could access the service for care and treatment.

The service team worked well together and where there were difficulties managers dealt with them appropriately.

Governance

Our findings from the other key questions demonstrated that most governance processes operated effectively at team level and that performance and risk were managed well.

Most of the governance processes within the service were effective.

The service building was safe and clean, and staff adhered to infection control procedures.

There were enough skilled and experienced staff to ensure that care and treatment was delivered in a safe way. Staff received regular clinical supervision and an annual appraisal. Staff knew how to report incidents and how to handle complaints.

All clients were risk assessed and staff had created risk management plans to mitigate any risks identified. Clients told us staff were kind, caring and supportive towards them.

The service adhered to the Mental Capacity Act and a doctor within the service carried out capacity assessments when needed.

Good

Residential substance misuse services

There was a clear framework of what must be discussed at a service, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of complaints and incidents at service level.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

However, the systems used to ensure staff were compliant with their mandatory training requirements were not effective. Staff were not up to date with mandatory training which related to the safe running of the service and equality and diversity.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

There was a clear quality assurance management and performance frameworks in place that were integrated across all organisational policies and procedures. Staff concerns matched those on the risk register.

Staff had access to the risk register. Staff were able to raise issues for inclusion on the risk register via the service manager.

Staff told us they could escalate concerns when required.

The service had plans for emergencies such as adverse weather, loss of information technology and premises, a flu outbreak or fire, floods or loss of water supply and bomb threats.

Managers monitored staff sickness and absence rates and ensured there was sufficient cover within the service to meet clients' needs.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Managers engaged actively other local health and social care providers to meet the needs of the local population.

The service used systems to collect data that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work.

The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Good

Residential substance misuse services

Information governance systems included confidentiality of clients' records. Staff received training in confidentiality and other training such as care planning and assessing needs also covered client confidentiality.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies when required such as the Care Quality Commission.

All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it.

The service had developed information-sharing processes and joint-working arrangements with other services where appropriate to do so.

Staff ensured the service confidentiality agreements were clearly explained to clients in relation to the sharing of their information and data.

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 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Staff were not up to date with all aspects of their mandatory training. The overall compliance rate for mandatory training was 74% and the shortfalls in compliance were in relation to training modules fundamental to safe practice and dealing with emergency situations. Compliance figures which were particularly low included: • Fire Training (70.59%) • First aid awareness (64.2%) • Health and safety (47%) • Basic life support (51.7%) • Environmental risk assessment (21.05%) • Automated external defibrillator and cardiopulmonary resuscitation (64.29%) • Moving and handling theory (21.05%) • Record keeping (42%) • Equality and diversity (57.1%)