High View Care Services Limited - 9 High View Road

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The service demonstrated good practice in a number of areas. There was a highly motivated team and the feedback from residents using the service was positive about the care they were receiving. The care was person centred and residents were involved in all aspects of their care
- The service has recently introduced a new model of care which combines psychological support and behavioural interventions to support the cognitive needs of residents with brain injury.
- The service showed commitment to improve the skills and knowledge of support workers to provide support for people with brain injury.

However we also found the following areas the service needs to improve:

Summary of findings

- There were a few areas for improvement to ensure the service was safe and responsive. This included ensuring that any identified safeguarding concerns were referred and escalated to the local authority and that complaints were responded to promptly and effectively.

Summary of findings

Contents

Summary of this inspection

Background to High View Care Services Limited - 9 High View Road

- The service provides accommodation and rehabilitation for up to five female residents with an acquired brain injury, predominantly as a result of long-term substance misuse. Although the service was not providing services for people who were currently using substances, the residents had a significant history of substance misuse.
- All five resident placements were funded by statutory organisations, either local authorities, NHS trusts or clinical commissioning groups.
- The service had been registered since 7 January 2011 to provide accommodation for persons who require nursing or personal care and accommodation for persons requiring treatment for substance misuse. The previous registered manager had applied to cancel their registration on 3 June 2016. An application for registration as a manager of regulated activities had been submitted to the CQC by the current manager on 28 June 2016.
- The last inspection of this service took place on 27 January 2015. The service was found to be meeting all the standards of safe, effective, caring, responsive and well-led. Previous inspections had been carried out on 8 August 2013 and 20 November 2012. The service had been found to be meeting all of the standards inspected.

Our inspection team

The team that inspected the service comprised of CQC inspector (inspection lead), an inspection manager, an assistant inspector and a specialist advisor experienced in working in substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited this location, looked at the quality of the physical environment, and observed how staff were caring for residents
- spoke with four residents
- spoke with the manager

Summary of this inspection

- spoke with the clinical neuro-psychologist, a support worker and neurological rehabilitation coach
- looked at five care and treatment records
- reviewed five medication folders including medicine administration records
- reviewed the statutory documents relating to the application and authorisation of the deprivation of liberty of four residents
- looked at policies, procedures and other documents relating to the running of the service

Information about High View Care Services Limited - 9 High View Road

This service was based in a converted house on a quiet residential road. People using the service were referred to as residents. Accommodation and rehabilitation was provided for up to five female residents. There were two support workers on duty 24 hours each day to ensure the residents safety and assist with activities of daily living. A clinical neuro-psychologist and neurological rehabilitation coaches provided therapeutic support. Most residents had been at the accommodation for approximately five years. One resident had been admitted last year.

What people who use the service say

Residents told us that they were generally happy and got on well with the staff. Residents found staff supportive and they enjoyed activities such as gardening, cooking, shopping and trips to the cinema.

One resident told us about their aspirations to leave the service and move to their own house. Another resident spoke positively about the progress they had made in managing their anger since being at the service.

One resident said that the house could be quite noisy and they did not like this.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The premises were clean, well maintained and the environment checked regularly, providing a homely environment for five female residents.
- Staffing levels were sufficient to meet the needs of the residents and the service did not use agency staff. Staff compliance with mandatory training was over 80%.
- Risk assessments were comprehensive and regularly reviewed.
- Controlled drugs and other medicines were stored appropriately and medicines management processes were effective and safe.
- Care was being discussed and reviewed regularly and a new system to monitor incident reporting was being introduced.
- The service operated in a transparent manner and was willing to apologise to residents when mistakes were made.

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

- Shift allocations and staffing rotas were not being monitored and staff were working excessively long, back to back shifts of up to 24 hours in the six weeks prior to the inspection. However, the manager assured us that staff were no longer permitted to work 24 hour shifts and has subsequently confirmed that no member of staff has worked a 24 hour shift since the inspection.
- Safeguarding referrals were not being made following incidents which required a referral to be made
- Staff worked with challenging and aggressive behaviour on a daily basis though training on 'break away' techniques was not provided.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- All residents received a full assessment of their physical and mental health on admission. These assessments were updated through monthly key working sessions. Recovery plans, including plans for assisting residents with their physical health, were individual and comprehensive.

Summary of this inspection

- The service was provided by support workers, assistant psychologists, neuro-rehabilitation coaches and literacy coaches. Coaches were involved in setting goals for residents and monitoring their progress towards achieving these.
- All staff had at least a National Vocational Qualification in Health and Social Care at level two and they were checked by the disclosure and barring service. When staff joined the service they were supernumerary for two weeks to enable induction training.
- Staff had regular supervision and annual appraisals.
- Documents relating to applications and authorisations of deprivations of liberty were up to date, clearly written and stored appropriately. There was evidence that the conditions of deprivation were being met.

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

- All residents' records were stored on a shelf in a locked office although they were not stored in a locked filing cabinet.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Residents said they were happy and comfortable with staff. Staff were kind, thoughtful and sensitive when interacting with residents. They responded to distress promptly.
- Every member of staff had a good understanding of residents individual needs, their history, their family dynamics, their cognitive functioning, their interests, and their plans for the future.
- Regular meetings to review care plans took place and residents were involved in care planning.
- The service worked with families to help them understand, engage with and contribute to the resident's recovery process.

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

- Residents were not involved in decisions to recruit staff.
- Records of residents meetings included details of personal information that residents had disclosed during the meeting that did not appear appropriate for circulation.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- The service had a homely atmosphere. It was based in a large converted house in a quiet residential street. Each resident had their own bedroom with doors they could lock to ensure their privacy and security.
- Residents were supported in participating in activities they enjoyed. Activities took place throughout the week.
- Residents were supported by staff to do their own shopping and cook their own food. Residents were therefore able to have any food in accordance with dietary requirements of their religious or ethnic group.
- Residents could be supported to access appropriate spiritual support. This included being supported to go to church and other religious meetings.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The approach that staff took towards working with residents reflected the values of respecting individuality, promoting independence and supporting self-determination.
- There were monthly managers meetings and resident review meetings. Tasks and responsibilities were shared between members of the staff team. Actions agreed at managers meetings were communicated to all staff by the manager who reported to the director.
- The organisation had a comprehensive risk register.
- Staff we spoke with were motivated and said that they enjoyed their work. They valued spending time with residents and were pleased to see residents make improvements.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Four residents were subject to authorisations of the deprivation of their liberty, including one resident whose authorisation was approved during the inspection. This authorisation was given within one month of the request being made.

Documents relating to deprivations of liberty were clear and stored appropriately. Documents clearly indicated the conditions of the authorisation and staff provided evidence to show these conditions were being met. When appropriate, residents subject to a deprivation of liberty were supported by a relevant person's representative who maintained regular contact.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The service was located in a converted three-storey house in a quiet residential area. There was a living room, dining room, kitchen, conservatory and staff office on the ground floor. Residents' bedrooms were located on the upper floors, along with two bathrooms.
- There were ligature points throughout the property. The risk this presented was mitigated by ensuring all residents had a risk assessment before admission and residents would not be admitted if they had a history of self-harm using ligatures. There had been no self-harm incidents relating to ligatures.
- The service was for female residents only.
- There was no clinic room at the property. Residents requiring a physical examination would be seen by their GP. One resident had a depot injection administered by the community mental health team. This was administered in the office to ensure that the residents' privacy and dignity maintained. There was no resuscitation equipment or emergency drugs at the property. If there was a medical emergency staff would call an ambulance.
- There was no seclusion room. Residents were not secluded in any rooms at the property.
- All areas were clean and well maintained. There were good quality furnishings throughout. Residents' bedrooms were spacious and fitted with a wardrobe, chest of drawers and a sink. Each bedroom was thoroughly cleaned once a week. This involved changing the bed linen, turning the mattress, changing the towels, dusting and washing the floor. There were two bathrooms adjacent to the bedrooms. The door to one bathroom opened immediately onto to a flight of stairs that led down to the facilities. This layout may present a risk of residents falling if they were disorientated or if their mobility was impaired.
- There was guidance on hand washing in all the toilets. The kitchen was equipped with a separate sink for hand washing. A cleaning rota was displayed in the kitchen showing which cleaning product and equipment should be used for each task. Mops and accompanying buckets were colour coded for specific tasks. A course on infection control formed part of the mandatory training.
- A full check of electrical wiring and sockets had been carried out in May 2014.
- Support staff were responsible for cleaning the property, working in collaboration with the residents. There was a list of cleaning tasks set out in the daily planning schedule. Staff signed the schedule each day to confirm that these tasks had been completed. Daily checks of the water temperature, the fridge and freezer temperature and the temperature of the medicines cabinet were taken and recorded each day. Managers completed a periodic health and safety checklist once a month. This included checks of the fire doors, emergency equipment, first aid boxes and other health and safety matters. Any concerns that arose from completing this checklist were recorded and passed to the maintenance contractor.
- Environmental risk assessments were not carried out for the building itself. Residents had individual risk assessments which included an assessment of any risk that the environment may present to them.
- There was a fire alarm installed that had been checked by a specialist contractor in April 2016. There were no personal alarm systems used in the building and no call buttons in any of the rooms.

Substance misuse services

Safe staffing

- The established staff level was for two support workers to be on duty at all times. The service operated a system of early, late and night shifts.
- We reviewed the staff rota for the six week prior to the inspection. Staff usually combined working on an early and late shift, thus being on duty from 7.00am to 9.15pm. On one occasion we found that only one member of staff had been on duty during the night shift. We found that on three occasions a member of staff had worked a late/night shift from 2.00pm until 7.00am the following day and on five occasions a member of staff worked an early/late/night shift, working 24 hours from 7.00am until 7.00am the following day. However, at the time of the inspection the manager gave an assurance that staff were no longer permitted to work 24 hour shifts. They have subsequently confirmed that no member of staff has worked a 24 hour shift since the inspection. At weekends, the manager was on-call. This involved the manager being available to take telephone calls from the service, although there was no policy setting out the responsibilities of the on-call manager.
- There were vacancies for a deputy manager and a team leader but the service did not use. The service did not use bank or agency staff.
- Mandatory training covered nine courses including health and safety, food hygiene, safeguarding, fire safety, brain injury and substance misuse. The overall compliance level was 81%. Eight of the 14 permanent staff had completed all nine courses, whilst three members of staff had only completed six. Mandatory training did not including breakaway training or training on the management of violence and aggression.

Assessing and managing risk to clients and staff

- Seclusion and restraint were not used.There was a strong emphasis on relational risk management involving staff developing a good knowledge and understanding of the resident and environment. This was translated into appropriate responses and care. We saw that staff responded to residents who were becoming aggressive by speaking with them calmly, encouraging the residents to move to a quiet part of the building, providing reassurance about the problem the resident was concerned about and providing some distraction from the immediate concern.
- All residents had comprehensive and detailed risk assessments. Risks could include self-neglect, absconding, aggression or being vulnerable to exploitation. Assessments were updated, although the assessments for some long-standing residents had not been updated for seven months.
- There was evidence of residents being involved in developing their risk assessments.The assessments included a summary of the resident's risk history, indicators of heighten risk and details of how staff should respond.For example, one risk assessment stated that when a resident became challenging staff should encourage her move to a quieter area of the property.
- The service was a 'dry' house. There was a notice which stated that residents could not bring drugs or alcohol onto the premises. It was not clear what the sanction would be if they did this. Most restrictive practices were imposed for specific residents with their agreement. For example, some resident's cigarettes were kept in the office and staff restricted resident's access to these. One resident's wardrobe was locked because they had a tendency to throw their clothes out of the window. Some restrictions imposed for specific residents did have an impact on all the residents, such as food being stored in locked cupboards and kitchen knives only being used under staff supervision.
- The door to the property was locked to prevent residents subject to a deprivation of liberty from leaving. Residents who were not subject to a deprivation of liberty could leave at any time.
- All staff had received training in safeguarding. An 'easy-read' version of the safeguarding policy was displayed on a notice board along with leaflets about safeguarding produced by the local authority. Staff were aware of the different types of abuse and said that if they suspected abuse they would complete an incident report and contact their manager. However, there had been no safeguarding alerts in the year up to the date of the inspection. We noted that one resident who was a risk of exploitation had an unplanned absence of over 24 hours which may have led to a significant risk of abuse. This was not reported to the local authority safeguarding team. However, the resident's absence was reported to the police and the service notified the Care Quality Commission of this.

Substance misuse services

- The service assisted residents in managing their medication. The medication administration records for all residents were clear and legible. Each resident had an individual medication care plan stating their preferences about the time they take their medication and the drink they liked to have when taking tablets. Medicines were stored in a cabinet in the office. Controlled drugs were stored in a locked box within the office. A register of controlled drugs contained records of when the drugs had been administered to residents, including the initials of the person administering the dose and the initials of a witness.
- Children visited the property very rarely. When children did visit, the visit was planned and supervised if necessary.

Track record on safety

- There had been 27 incidents in the twelve months before the inspection. Incidents tended to involve aggressive behaviour, verbal abuse, physical abuse or absconding.

Reporting incidents and learning from when things go wrong

- Staff recognised that verbal abuse and aggressive behaviour was an intrinsic characteristic of brain injury and incidents of this nature were routine within the service. Physical and verbal abuse was only recorded as an incident when it was particularly excessive or if it took place outside the normal routines of the service. For example, reported incidents frequently took place away from the property such as on trips to the hairdresser or at medical appointments. This approach to recording meant that the threshold for reporting and investigating was high.
- Incidents of verbal aggression were recorded on the resident's record. These were discussed at team meetings and at a monthly resident case review attended by senior staff and psychologists. Antecedent behaviour consequent (ABC) charts were used as an observational tool to record information about a specific behaviour. The ABC charts were a way of recording what was happening immediately before an incident in order to identify any themes or patterns of behaviour that could be addressed to reduce the level of risk.
- Staff were all required to read a communication book when they began their shift. This book was used to record details of any incidents and events that may lead to heightened levels of risk, including details of how any situations had been dealt with to ensure a consistent approach.

Duty of candour

- Staff showed that they acted in an open and transparent way, and were willing to apologise to residents when mistakes were made. For example, the manager told us that he had apologised to a resident when staff took a long time to complete an application for the resident's travel pass and that they apologised when a mistake was made in recording the time of a medical appointment. There had been no notifiable safety incidents that required the service to notify the relevant person and provide support in relation to that incident.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- All residents had received a full assessment of needs covering their mental capacity, physical health and mental health.These assessments were used to develop holistic recovery plans that were specific to the individual needs of the resident. Recovery plans included the arrangements for personal care, developing skills through activities for daily living, arrangements for managing the resident's money, medication, preferred methods of communication and details of the resident's spiritual and cultural activities. One recovery plan explained how the resident responded well to praise and this was seen as an effective way of developing their skills. Another plan spoke positively about the resident's flair for arts and crafts and that they enjoy going to Zumba classes.
- Physical health assessments were comprehensive. They included information on residents' mobility needs, personal care needs, hygiene and medication. One plan also included information of the resident's cognitive patterns.

- Assessments and recovery plans were reviewed each month in key worker sessions with a support worker or neuro-recovery coach.
- All residents' records were stored on a shelf in a locked office although they were not stored in a locked filing cabinet. This office was used for meetings with residents and their families. This meant that the security of patient information could have been breached.

Best practice in treatment and care

- The provision of psychological services was led by the deputy director of clinical therapeutic services who had been in post for four months. Psychological therapies were designed to help residents with poor short-term memory and concentration. This included individualised behavioural plans as well as therapeutic interventions such as board games and discussion groups.
- The deputy director provided training on challenging behaviour and understanding brain injury.Through this training staff were supported to have a better understanding of why residents behaved in the way they did and develop a more compassionate approach to challenging behaviour.
- Residents' physical health was constantly reviewed by support workers. Residents were registered with a local GP. Some residents were receiving specialist health care and treatment from the local hospital.
- Formal outcome measures were not used.However, care planning involved setting goals and targets with residents. Goals were typically quite modest, such as a resident making their tea for a month, and were based on the specific abilities of the resident. Reviewing residents' achievements in meeting these goals enabled staff to monitor their progress.
- There had been 33 quality visits to the property by senior managers in the 12 months prior to the inspection. Reviews of quality, health and safety and medication were done by managers within the organisation. External agencies were used to check and maintain the fire alarms, gas and water. An independent pharmacy had carried out a medication audit in October 2015.

Skilled staff to deliver care

- The staff team consisted of nine support workers, two neuro-rehabilitation coaches, a manager, a deputy manager, a team leader, a counsellor, a literacy and numeracy coach, and two assistant psychologists.
- From Monday to Friday, two neurological rehabilitation coaches worked two days each week at the service. The support of rehabilitation coaches meant that daily trips out to the shops or park could be facilitated and staff were able to spent time individually with residents.
- The staff team was stable with most support workers having been in post for a number of years. Support workers were qualified to at least level two of the National Vocational Qualification (NVQ) in health and social care. Assistant psychologists and neuro-rehabilitation coaches were psychology graduates who tended to stay with the services for about one year as part of their professional development. The manager was a qualified social worker with experience in the field of brain injuries. Records showed the date and reference number of disclosure and baring service (DBS) checks for all staff.
- When new staff joined the service they were supernumerary for two weeks.During this time they received an introduction to service, were guided through policy, completed mandatory training using online training modules and shadowed experienced members of staff.
- Staff usually received supervision every month. Out of the nine supervision records we reviewed, three members of staff had gaps of two or three months. All permanent staff had had an appraisal within the last 12 months. Team meetings took place each month. During these meetings each resident was discussed, along with rotas and housekeeping.
- Most training was carried out using online training modules. In addition to their mandatory training, staff had received training in brain injury provided by the deputy director of clinical and therapeutic services.
- All staff attended an annual training day which included training on communicating and speaking with people with brain injury. The staff we spoke to said this training was helpful.

Substance misuse services

- Poor performance was addressed with supervision sessions at which staff were encouraged to reflect on how difficult situations could be handled differently.

Multidisciplinary and inter-agency team work

- Multidisciplinary team meetings were held once a month at which all of the residents were reviewed. The service operated a system of three shifts per day.There was a handover meeting at every shift change but these were not recorded. Staff were required to read and sign a communication book at the start of each shift. This book contained information about any incidents, concerns about patients' behaviour and any practical matters that staff coming on shift needed to be aware of.
- Most residents all received care and treatment from other agencies such as substance misuse services or the community mental health team. Care Programme Approach meetings were held every six months for residents receiving mental health services. However, it was not clear on the recovery plans which other agencies the residents were receiving support from. There was no involvement from other agencies in developing the recovery plan and no contact details of other people involved in the residents care and treatment.

Adherence to the Mental Health Act (if relevant)

- The service was not registered to provide care and treatment for people detained under the Mental Health Act 1983.

Good practice in applying the Mental Capacity Act. (if people currently using the service have capacity, do staff know what to do if the situation changes?)

- Four residents were subject to authorisations of the deprivation of their liberty, including one resident whose authorisation was approved during the inspection.
- Documents relating to deprivations of liberty were clear and stored appropriately. Documents clearly indicated the conditions of the authorisation and staff provided evidence to show these conditions were being met. When appropriate, residents subject to a deprivation of liberty were supported by a relevant person's representative who maintained regular contact.
- Staff understood that residents had difficulty in retaining information and weighing up information as part of a decision making process. Staff had developed a good understanding of residents' views and preferences over time. Staff at the service knew residents well and supported them to make decisions about daily choices such as what clothes to wear and what to eat.

Equality and human rights

- The service provided care and treatment according to the individual needs of each resident. The service was sensitive to the fact that all residents were female and ensured the there was a female member of staff on duty at all times.

Management of transition arrangements, referral and discharge

- Residents tended to stay at the service for a number of years. The service described itself as offering 'slow stream' rehabilitation with the primary focus on ensuring the resident's well-being on a daily basis. Transitions and discharges were therefore infrequent. Residents were admitted from inpatient health services such as mental health assessment wards, substance misuse detoxification units or intense neurological rehabilitation services. Discharge was planned in conjunction with commissioners and community mental health services.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Throughout this inspection we saw that staff were kind, thoughtful and sensitive when interacting with residents. Staff responded straight away to residents' questions and requests for assistance. When residents became agitated staff spoke to them quietly and gently encouraged them to resolve their problems calmly.
- Residents said they were happy and comfortable with staff. One resident said that staff were supportive and helped them to do the things they liked to do.They also said that staff understand their history, allow them time to reflect on the past and take a real interest in them. Another resident said that staff managed difficult situations very well and they felt that they managed their own anger much better as a result.

Substance misuse services

- Every member of staff, from the managing director to the support workers had a good understanding of residents individual needs, their history, their family dynamics, their cognitive functioning, their interests, and their plans for the future. This enabled all the staff to engage in a positive and supportive way with residents.

The involvement of clients in the care they receive

- A provisional care plan was developed for residents before they arrived at the service, based on pre-admission assessments. On arrival, new residents met with staff and other residents and were shown around the property. A support worker spoke to the new resident about what they could expect from the service and explained the rules of the property, such as the arrangements for smoking and that alcohol was not permitted on the premises. Over the first two to four weeks a more detailed recovery plan was developed with the support of psychologists.
- Residents met with a support worker once a month to review their progress. There was clear evidence that residents had been involved in the development of their recovery plans. These plans included details of residents' interests and preferences.
- A local advocacy service was available to assist residents in making complaints.
- The service worked with families to help them understand, engage with and contribute to the resident's recovery process. The service actively supported residents to engage with their families. This included helping residents to search for family members and make contact, and support to visit family members even if they lived a long way away.
- Records of residents' meetings showed they took place each month and were usually attended by four residents. They were facilitated by a support worker. Meetings included discussions about which activities that residents had enjoyed. Records also included details of personal information that residents had disclosed during the meeting. This meant that the privacy and dignity of residents was compromised.
- Residents were not involved in decisions to recruit staff and there were no plans in place to involve residents in the recruitment of staff.
- Residents were able to make some advance decisions. During their first week with the service, and end of life plan was sensitively discussed with the resident, including details of their preferred funeral arrangements.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- The service had always been full since it opened in 2011. There was a waiting list of four people. The service could accept referrals from anywhere, although most residents had some connection with the local area.
- The service accepted referrals for people who had a brain injury and a history of substance misuse. The service did not accept referrals for people with a significant history of violence or people who were still using drugs or alcohol. People referred to the service usually had poor mental health or a learning disability. Residents were admitted from inpatient health services such as mental health assessment wards, substance misuse detoxification units or intense neurological rehabilitation services.
- Once a referral had been received by the service, a manager and psychologist would visit the person being referred to carry out an assessment. On the basis of this assessment a care package would be planned and presented to the commissioning panel, along with details of the fees that would be charged. If the proposal was accepted, arrangements would be made for admission.
- Plans for discharging residents were usually initiated by the commissioning authority based on an assessment of the resident's progress. During our inspection, one resident was preparing for discharge.They had been supported to visit their proposed new accommodation and consider other alternatives. The resident had had the opportunity to discuss their views on the proposed move and to talk about their concerns and worries about the plans.

The facilities promote recovery, comfort, dignity and confidentiality

Substance misuse services

- The service provided a homely environment. It was based in a large converted house in a quiet residential street. Each resident had their own bedroom with a sink, wardrobe and chest of drawers. The residents shared two bathrooms. On the ground floor there was a living room, dining room, a large kitchen, a utility room and a conservatory. Residents had unrestricted access to a well-maintained garden. There were sufficient separate rooms within the property to enable residents to meet with visitors in private.
- Residents were able to make telephone calls in private.
- Residents had unrestricted access to a well-maintained garden.
- Residents said that the food was good. An inspection under the Food Safety Act had been carried out by the local authority in December 2014. The service had been awarded five stars for food hygiene. Residents could access the kitchen at any time with support from staff.
- Residents were able to personalise their bedrooms. Many residents had put up pictures and photographs of their families. Residents could lock their bedroom doors to ensure their property was secure.
- Residents were supported in participating in activities they enjoyed. This included daily trips out to the shops and parks in the surrounding areas. There were also frequent trips to the seaside and other places of interested. Activities took place throughout the week.

Meeting the needs of all clients

- The service did not have disability access. The facilities in the property were located across three floors.There was no lift. Residents' mobility was assessed at the point of referral. People were not admitted to the service if their mobility was significantly impaired.
- There was a notice board in the hallway with information about safeguarding and advocacy services. Staff supported residents to understand information about care and treatment in response to the specific communication needs of each resident.
- Residents were supported by staff to do their own shopping and cook their own food. Residents were therefore able to have any food in accordance with dietary requirements of their religious or ethnic group.
- Residents could be supported to access appropriate spiritual support. This included being supported to go to church and other religious meetings.

Listening to and learning from concerns and complaints

- There had been no formal complaint in the 12 months before the inspection.
- The service had a complaints policy that stated all staff had a responsibility to respond to complaints being made. Managers were required to provide an initial response within 72 hours and investigate the matter within 21 days. All investigation reports and decisions were passed to the director.
- During our visit, one resident told the manager that her bedroom was too hot. She said that she had raised this complaint before but nothing had been done

Are substance misuse services well-led?

Vision and values

- The core values of the service were to respect individuality, promote independence and support self-determination. The service aimed to achieve this through positive neuropsychological interventions that targeted improved well-being and rehabilitation. The approach that staff took towards working with residents reflected these values.
- The service did not have any specific agreed, written objectives. However, the manager told us the priorities for service were to recruit more staff, end the practice of working 24 hour shifts and to improve the communication skills of all staff when they are working with other professionals.
- High View Services Ltd was a small organisation with four properties around the same area. The managing director frequently visited the service and she was well known to both staff and residents.

Good governance

- The manager was responsible for the team leaders and residential support workers. There were monthly managers meeting and resident review meetings. These meetings provided a focus on interventions, improvements or deterioration, staffing recruitment and

retention issues and key performance indicators. Tasks and responsibilities were shared between the members of the staff team. Actions taken communicated to all staff by the manager who reported to the director.

- Mandatory training levels were above 80%, staff received monthly supervision, and no concerns were raised about the number of staff on each shift. We saw that most staff time was dedicated to working directly with residents. Quality checks were carried out by senior manager each month. There was evidence that staff reflected on incidents in team meetings and developed their approach to working with residents in response to incidents. There was a good understanding of the Mental Capacity Act and the documents relating to deprivations of liberty were all in order.
- The service was developing key performance indicators. We were shown a record of therapy hours provided to each resident over a period time.This was measured against a target of hours to be provided. The service planned to develop these KPIs further to review and how care was being provided to residents on a daily basis.
- The manager felt that they had sufficient authority to carry out their role.
- The organisation had a comprehensive risk register that staff could contribute to through the manager.

Leadership, morale and staff engagement

- In May 2016, the sickness rate was 4% and staff turnover was 10%
- No concerns about bullying or harassment were raised. Staff we spoke with said they were aware of the whistleblowing policy and would feel able to raise concerns with their manager.
- Staff we spoke with were motivated and said that they enjoyed their work. They valued spending time with residents and were pleased to see residents make improvements. The manager was keen to support the professional development of the team by encouraging them to take on more responsibility.

Commitment to quality improvement and innovation

- The manager of the service was a member of the national Brain Injury Social Work Group. The manager was pursuing plans to become a practice educator and take social work students on placements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that they work in conjunction with the local safeguarding authority to ensure that service users are protected from abuse and improper treatment.
- The provider should ensure that all records are held securely.
- The provider should ensure that personal information discussed in residents' meetings is not documented or circulated in written meeting minutes.