Longreach

Quality Report

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Date of inspection visit: 27th and 28th September 2016
Date of publication: 25/01/2017

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:

- Trained and accredited counsellors provided group work and one-to-one sessions suitable for clients in rehabilitation with qualifications approved by the British Association of counsellors and psychotherapists.
- Staff were kind, patient and supportive to clients and care was client focused. New clients received a welcome pack of information and a pack of toiletries and new bedding, which they could take with them when they left. Clients felt safe and well cared for.
- Staffing levels were safe and had been set using ratios of client to staff recommendations from the British association of counsellors and psychotherapy of one member of staff to six clients as the minimum requirement. Clients had up to date comprehensive risk assessments and recovery care plans that were personalised, holistic and had goals identified.
- Staff morale was high and all the staff we spoke with said they felt well supported by their manager and each other. Staff received regular supervision, appraisals and training. New staff received an induction to prepare them for working within the service.

Summary of findings

- The service managed quality, performance and risks well. There was evidence of learning lessons and making improvements from investigated complaints. Audits were reported to the board and disseminated to the wider team.
- The service demonstrated a commitment to quality and innovation.

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

- Medicines for self-administration were not given to clients with the full prescribing information and self-medication was not always monitored.
- Although staff demonstrated a good understand of mental capacity, mental capacity act training was not mandatory and only 50% of staff had undertaken this.
- There was lockable space for clients to store valuables but single and double bedroom doors were not all lockable.
- Notifications, such as safeguarding were not always submitted to CQC.

Summary of findings

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Substance misuse services

Summary of this inspection

Background to Longreach

Broadreach House is the overall provider and registered charity offering treatment and support services for men and women who have experienced difficulties with substance abuse. It consists of three residential services across Plymouth, including Longreach. Broadreach, Longreach and Closereach are residential services and Ocean Quay is a community day service.

Longreach is a 22 bed rehabilitation service for women who have completed detoxification.

Longreach has a large main house and adjacent cottage with a garden. The cottage is part of a step down facility for clients who were progressing to greater independence and had its own communal kitchen, dining area, lounge and bedrooms.

The minimum stay for clients is 12 weeks with an option to extend if needed. There were 17 clients living at the accommodation when we inspected. The majority of clients were funded by community drug and alcohol services and local authorities. There were clear exclusion criteria. For example, the service did not accept clients who had a conviction for arson or offences against children, or people with severe mental health problems.

Longreach has obtained a grant to extend and renovate the buildings creating ensuite bedrooms, additional counselling rooms and a nursing and detoxification suite. Plans have been submitted to the local authority.

Longreach has a registered manager in place and was registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse

The provider has previously been inspected in 2012, 2013, 2014 and 2015 and was compliant with regulations at the time of this inspection.

Our inspection team

The team that inspected the service was led by CQC inspectors Julia Winstanley and Sarah Lyle, and comprised a specialist CQC pharmacist inspector, a CQC assistant inspector, and a consultant psychiatrist who had experience of 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?

Summary of this inspection

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 the location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with eight clients
- spoke with the registered manager
- spoke with three other staff members
- spoke with one peer support volunteer
- attended and observed one hand-over meeting
- observed a trauma and recovery group
- collected 13 comment cards from clients
- looked at seven care and treatment records for clients
- looked at five prescription and medicines administration charts
- reviewed the medicines management arrangements
- looked at five staff files
- looked at four supervision records
- looked at policies, procedures and other documents relating to the running of the service

What people who use the service say

We spoke with eight clients who all told us that they felt safe and well cared for.

Clients were very positive about the staff and described them as caring and supportive. Clients described staff as non-judgmental and confirmed that they were treated fairly and with dignity and respect. Clients were very positive about the therapies provided and told us that that there was usually enough time to go out to the shops and for walks. However, people consistently commented that they wanted to have more access to television during the evenings.

Clients had also completed 13 comments cards to tell us what they thought of the service at Longreach. Six were very positive about the service. Four comments cards were mixed and three were negative. Negative comments were mainly in relation to communication, and training, particularly about staff that worked in the evening. Three clients also commented about the television restrictions.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

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

- One medication administration record showed that missed doses had not been followed up with the GP or specialist nurse for advice and guidance.
- Clients who were self-medicating had not always received the original medicines pack with the prescribing or dose information. This could have led to accidental mix-ups and errors.
- Although the safeguarding lead and local authority were appropriately alerted when there was a safeguarding concern, the provider did not always notify CQC about allegations of abuse.

However, we also found the following areas of good practice:

- The building was clean, had good furnishings and was well-maintained
- Staffing levels had been set using ratios of client to staff recommendations from the British association of counsellors and psychotherapy.
- There were no vacant staff positions and only bank staff that were familiar with the service were used to cover shifts. Staff sickness was low.
- Clients had up to date comprehensive risk assessments and risks were well managed.
- Mandatory training records were up to date for all staff.
- The service fulfilled their duty of candour and had an open culture of reporting and sharing learning.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients had recovery care plans that were personalised, holistic and had goals identified.
- There was good access to physical health care and examples of proactive support to improve physical care for individuals.
- Staff had access to regular group supervision and one to one supervision meetings, including external supervision for therapy staff.

Summary of this inspection

- There were good transitional arrangements for discharge and support.

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

- Mental Capacity Act and Deprivation of Liberty Safeguard training was not mandatory for staff.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were kind, patient and supportive to clients and there was opportunity for patients to discuss their care needs
- Clients told us that they felt safe.
- A buddy system with other clients and a welcome pack helped new clients to settle in.
- There were opportunities to feedback about the service or the care and clients knew how to do this.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The provider managed a range of supported housing locally which clients could move on to.
- Rooms were personalised and clients were able to keep the duvet, pillows and bedclothes that they were provided with on arrival.
- There were individual safes for each client in bedrooms to store valuables.
- Clients knew how to complain and comment
- Complaints management was embedded in the culture of the organisation and staff knew how to handle formal and informal complaints

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

- There was no facility to lock bedroom doors.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There was a clear organisational structure with defined responsibilities for governance and for accountability.

Summary of this inspection

- Board meetings took place every two months and the venue rotated between the providers different sites, including Longreach.
- The provider reported to the national drug treatment monitoring system and was part of the clinical governance forum for Plymouth.
- Staff morale was good and staff said they felt well supported by their manager.
- Senior staff were supported to undertake leadership courses.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated an awareness and understanding of mental capacity and training on the Mental Capacity Act and Deprivation of Liberty Safeguards was provided. However, this was not part of the mandatory training programme and only half of the staff had completed recent Mental Capacity Act training.
- As part of the admission criteria client's mental capacity was assessed before admission, and those who lacked capacity were not admitted.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- Longreach comprised of a converted large house, garden and adjacent cottages. The buildings were visibly clean and well maintained. Staff were up to date with infection control training and this included on line and face to face training. Staff had recently completed body fluid spillage training. Alcohol hand wash gels were throughout the building, including the main entrance, medicines room and dining room.
- Comprehensive cleaning checks were undertaken. There were daily, weekly and fortnightly tasks as part of a comprehensive cleaning rota. Environmental risk assessments were undertaken and staff recorded issues requiring maintenance for the provider's maintenance staff which were dealt with promptly.
- Bedrooms and communal areas were homely and therefore not ligature free. Ligature points were adequately mitigated through the pre assessment process and individual risk assessments. People who were at risk of self-harm, such as using ligatures were not admitted, as the environment was not appropriate to accommodate this level of risk.
- There were no blanket restrictions. Restrictions were part of the therapeutic programme and were agreed with clients in residents meetings. Items that were restricted were appropriate for the setting and client group and were explained to clients and this was included in the written information given to clients. The group had agreed to restrict television in the evening to provide more support for each other. However, some clients in the service were not happy about this.

Safe staffing

- Staffing levels had been set using a ratio of client to staff recommendations from the British association of counsellors and psychotherapy of one member of staff to six clients as the minimum requirement. There was one counsellor to five clients during the day at Longreach. There were four counsellors, including two senior counsellors and a trainee counsellor who worked during the day. A health care coordinator was responsible for medicines management. A team of eight support workers supported clients during the evening and weekends with a support worker on a sleeping night shift. On call counsellor and manager were available at night and weekends.
- The registered manager also managed the provider's male-only rehabilitation service (Closereach) and split their working week between the two services. Two volunteers supported the service.
- Any additional staffing to cover sickness or absence was managed across the three services. The service did not use agency and locum staff. Staff confirmed that there were no staff shortages. There were no vacancies and sickness rates were low. Sickness was 2% in the 12 months up to July 2016.
- A training record was kept and staff were up to date with all mandatory training. This included fire safety, manual handling, health and safety, infection control and medicines management.
- Staff had all received recent safeguarding of vulnerable adults training and child protection training. The local authority provided adult safeguarding training. The service had safeguarding leads for adults and children. The safeguarding policy had been written in line with

the local authority guidelines. Safeguarding referrals were recorded and discussed at senior board meetings. All senior staff had received children's safeguarding training. This was currently being rolled out to all staff.

- Staff knew how to make a safeguarding alert and had made five safeguarding alerts this year**.** There was clear understanding of what constituted safeguarding from staff at all levels. For example, when a client had made a disclosure appropriate action was taken. However, staff were not aware to make a notification to CQC when they made safeguarding alerts when there was abuse or an allegation of abuse.

Assessing and managing risk to clients and staff

- The service required referrers to provide a risk assessment. Risk assessments were completed on admission and followed up six weeks later. Risk assessments were updated at an end-of- treatment review and after any incidents. Risks were discussed as a team. All staff were aware of discussion of client risk at multi-disciplinary team meetings. We observed a handover meeting where managing risk was included.
- Each client records that we reviewed had up to date comprehensive risk assessments. All had a risk management plan. Staff gave us examples of working with clients to reduce risk. For example, collaboratively working with a client who self-harmed to reduce the use of high risk ways of self-harming and encouraging the use of relaxation techniques.
- All staff involved in medicines processes had undertaken required training and medicines were order supplied and stored appropriately. Clients' were supported to self-administer medicines when leading to discharge in order to regain independence.
- Medication was stored securely in locked cupboards within the clinic room.
- Refrigerated medicines were stored in a locked fridge. This was checked daily and was within normal range. Room temperatures were checked and recorded daily.
- We reviewed five medication administration record folders. All records contained medication risk assessments for clients. This contained clear information and action to be taken if the client became unwell, such as a client with diabetes. However, there were missed or refused doses of an oral medicine for one person, which had not been followed up with the GP or specialist nurse.
- Medicines suitable for self-administration were risk assessed for abuse potential and clients were supported to self-administer medicines when leading up to discharge in order to regain independence. However, clients were given some medicines to take themselves without any prescribing or dose information. Some medication was outside of the original packaging so clients could not see the instructions. This was called secondary dispensing and could lead to accidental mix-ups and errors. We raised this with the provider who took steps to address this.
- There was one member of support staff who lone worked from 11pm and slept over at night. Support could be accessed from one of the provider's on-call counsellors and managers by telephone. Staff felt that arrangements for the sleeping rota and lone working at night were safe and told us that there had not been any incidents when they had felt at risk from clients.

Track record on safety

- The provider had reported eight serious incidents that required further investigation between May 2015 and May 2016; six of these were safeguarding incidents that were reported to the local authority.

Reporting incidents and learning from when things go wrong

- There was a clear procedure for reporting incidents and staff were encouraged to report. Staff gave us examples of the type of incidents that they reported. Incident reports included a graded risk matrix. Incidents were discussed in handover meetings. The provider was able to demonstrate learning from incidents.
- There were no recent examples of serious incidents. The provider had demonstrated learning from an incident in 2014. A critical incident investigation took place and an action plan completed with evidence of lessons learnt.

Substance misuse services

Duty of candour

- We looked at incident investigations and complaints management. These showed that the provider adhered to duty of candour requirements. Policies and procedures took account of duty of candour, such as sharing outcomes from complaints and investigations.

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

Assessment of needs and planning of care

- We reviewed seven client care records. All pre-assessment information was filed and accessible, such as assessments from the provider's detoxification unit, or from the referrer if being referred from elsewhere. There was evidence of consent to treatment, information sharing and confidentiality agreements.
- Each record had a recovery care plan that was up to date, personalised and holistic. These covered all the domains including physical health, mental health, social functioning, criminal involvement and psychological health. Clients had signed their recovery care plans and this had been scanned in. There was evidence that recovery care plans were discussed at multi-disciplinary team meetings.
- Client notes were stored securely in lockable cabinets within locked rooms.

Best practice in treatment and care

- Groups were facilitated and planned. Boundaries were established at the beginning of meetings and were followed. Staff provided group work and one-to-one sessions suitable for clients in rehabilitation and included recovery maintenance, trauma recovery and life story work. We observed the first of a ten-week programme looking at trauma and recovery, which was well facilitated with clear boundaries and support.
- Clients attended a weekly facilitated community group that they shared with clients at a woman and children's substance misuse service in Plymouth. This was a programme of support in relation to domestic abuse.
- There were examples of good physical health monitoring and liaison with specialist community staff. Staff had been proactive in supporting a client with mobility problems and sourcing specialist support and adaptions that had not been available prior to their admission. All clients were registered at a local GP surgery and the named GP attended multidisciplinary meetings.
- The service participated in an annual cycle of regular audits, including care plans and infection control, medicines management and safeguarding. This was used to inform practice.

Skilled staff to deliver care

- A range of staff supported the residential unit. Care staff followed a programme of induction and training and therapeutic staff had all received specialist training. Staff were skilled with specialist training, for example, counsellors were qualified and held postgraduate diplomas in counselling and or addictions. All the counsellors had a minimum qualification of either a level three diploma in professional counselling qualification or an equivalent accredited course. Counselling qualifications were approved by the British Association of counselling and psychotherapy.
- A member of staff was trained in eye movement desensitization and reprocessing therapy which was used to help with the symptoms of post-traumatic stress disorder (EMDR). There was a clear policy and flow chart for EMDR, with referrals discussed at the multi-disciplinary team meeting and with the provider's psychiatrist to agree suitability
- Staff told us that they felt well supported. Staff felt particularly supported by the registered manager.
- Staff received a regular appraisal. We spoke with staff and reviewed five staff records that confirmed this. All staff received regular one-to-one supervision and group supervision. Counsellors were able to access external supervision. Therapeutic staff undertook external clinical supervision once a month.
- Supervision records confirmed that staff had met or exceeded the supervision requirements as defined by their policy. For support workers this was a one to one supervision session every three months in addition to the monthly group.

- New staff received a corporate induction. All staff had received an annual appraisal and new staff had received a probationary appraisal. New counsellors observed group sessions before taking responsibility for facilitating the group.
- Poor staff performance was addressed promptly by the registered manager.

Multidisciplinary and inter-agency team work

- The registered manager attended weekly multidisciplinary team meetings at Broadreach, which was the provider's detoxification service. Representatives from the provider's other services attended these meetings as well as the consultant psychiatrist and non-medical prescriber.
- There were effective working relationships with teams outside the organisation, such as the local authority social services and GP. The GP attended the weekly multi-disciplinary meetings. The service worked closely with a neighbouring substance misuse mother and child service in Plymouth who reported positively about the teamwork and good communication between the services.
- New referrals, planned admissions, unplanned discharges and safeguarding were discussed in the meetings, which were minuted. The minutes were sent to all staff. The provider's consultant psychiatrist saw clients if required and liaised with the client's GP regarding any mental health issues.
- Twice daily handover meetings took place, so that all staff was aware of issues that had occurred during the previous shift. We observed a handover that focused on risk and support that staff might need.

Good practice in applying the MCA

- Mental Capacity Act and Deprivation of Liberty Safeguard training was not mandatory for staff and only 50% of staff had undertaken Mental Capacity Act training. However, mental capacity was assessed before admission, and clients who lacked capacity were not admitted to Longreach. Clients had to consent to admission to the unit. There was evidence of consent to treatment and the sharing of information in the care records that we looked at. Staff demonstrated an awareness of capacity; such as if capacity appeared to change.

Equality and human rights

- Equality and diversity training was mandatory for all staff and the provider had an equality and diversity policy which staff were aware of.

Management of transition arrangements, referral and discharge

- Referrals were accepted from community drug and alcohol services and from the provider's own detoxification service. Discharge was planned with the client prior to admission and throughout the treatment. Formal reports were sent to the referrer, and the counsellor made contact with the referrer within 24 hours of discharge.
- Clients were discharged to the care of the community drug and alcohol teams. There was additional support post discharge being provided through a new women's substance misuse team and the service was in the early stages of providing a new shared community and outreach support service offering more individual and group support for women who had been discharged. The sunflower recovery project started in early October and aimed to support clients being discharged from Longreach as well as another local women's substance misuse service.
- The admission policy included a policy for if clients left the service before the end of treatment.
- The provider also managed a range of supported accommodation in the local area that clients could move on to.

Are substance misuse services caring?

Kindness, dignity, respect and support

- We observed clients being treated with kindness and respect. There was reciprocal warmth between clients and staff.
- Clients confirmed that staff all treated them with dignity and respect. All clients told us that they felt safe and well cared for and found the rules to be fair and consistent, although there were some concerns about communication. Clients told us that they felt safe and

we received a number of very positive comments about how good the staff were and how they had gone out of their way to support and help clients, particularly the therapy staff.

The involvement of clients in the care they receive

- There were regular client feedback questionnaires undertaken, the latest showed a 69% satisfaction where clients had expressed satisfaction about their care.
- Clients told us that they were involved in their individual recovery care plans and had opportunity to discuss their needs.
- New clients received a welcome pack of information, and a pack of toiletries and new bedding, which they were able to take with them when they left. Clients were given a tour of the building on arrival and were informed about fire safety. Clients who had been at Longreach for a while "buddied" people who were new to the service, to help them settle in.
- There were opportunities to feedback about the service through one to one meetings or weekly house meetings. Clients attended these meetings and they were minuted. Despite the processes in place, two people commented that their views were not listened to. Two clients commented that there were communication issues particularly in relation to the evening staff.
- Some clients had been involved in the development of a new service to provide dedicated outreach and community support which clients were involved in, such as interview panels.

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

Access and discharge

- Occupancy rates were at 80% with 17 clients at the time of our inspection. This allowed the service to be responsive in accepting new referrals as well as having sufficient numbers for the service to be sustainable.
- Length of stay varied but was usually a minimum of twelve weeks. Length of stay could be extended if a longer period of rehabilitation was felt to be clinically appropriate and the provider worked with the funding authority to agree a further period of treatment.
- Beds were always kept for clients to return to from periods of short-term home leave, such as to spend time with children and family.
- The service focused on after care support and had set up a weekly group facilitated by ex-residents.
- The provider managed a range of supported housing locally which clients could move on to.
- The service had identified the need for more support after being discharged to the community and had worked in partnership with another women's service to provide a more support after discharge including outreach support and group work Interventions. This was in the early stages of development.

The facilities promote recovery, comfort, dignity and confidentiality

- There was access to drinks and snacks, such as fruit, yoghurt, teas and coffees at all times. During therapy times, this was discouraged.
- Meals were cooked freshly on the premises. Clients told us that food was fresh and home cooked and options, such as sugar free options were always available. At weekends clients cooked for each other. Clients in the self-catering flats made their own food.
- The majority of rooms were shared between two people with a room divider for privacy. Clients were aware of this prior to admission and had all consented to sharing a room. None had ensuite bathroom facilities. There were plans to create more single rooms and ensuites that had been submitted and were awaiting planning approval.
- There were communal dining and lounge and rooms for individual and group therapy. There was a large garden for client use including a greenhouse for clients to pursue gardening interests.

- Clients could bring personal items with them and we saw that clients had made their rooms comfortable and individual. There were safes in each room and locked cupboards; however, none of the bedroom doors had locks on them.
- Clients were able to keep the duvet, pillows and bedclothes that they were given on arrival and take these with them when they were discharged.
- Clients were supported to develop "life skills" to prepare for independent living. This included cleaning, and peers supported each other to improve these skills. Clients could access a range of courses from the provider's day care service (Ocean Quay) and were assisted to engage with local colleges and universities to get involved in further training and education.
- There were some activities at weekend and evenings a number of clients from the service were working with a local theatre company.

Meeting the needs of all clients

- The service accommodated clients with disabilities, including wheelchair users. There were ramps into the main entrance and group room and a stair lift to the first floor bedrooms. There was an accessible bathroom. Some of the corridors were narrow which could prevent access for people in larger wheelchairs, however the service was in the process of improving access further and had submitted plans for two ensuite accessible bedrooms.
- There was information on treatments and local services. Staff could access interpreters and information in different languages if needed. Leaflets in other languages were sourced as needed.
- There was choice of food to meet dietary requirements of religious, ethnic groups and dietary needs. The cook catered for a range of diets such as vegan, halal and gluten free and provided healthy options.
- Clients were supported to access appropriate spiritual support in the community and there were quiet areas in the house and grounds.

Listening to and learning from concerns and complaints

- There was an established process for conducting an investigation and an agreed template for providing a report that included findings and recommendations. There had been one complaint received in the previous 12 months. This was being investigated by the manager of the provider's detoxification unit because the complaint was about staff.
- Staff knew the complaints process and there was a policy in place. The complaints process was clearly set out in the staff handbook and was part of the staff induction process. We saw that this had been discussed at recent staff meetings. Complaints were audited quarterly.
- Clients were familiar with how to complain and there was a suggestion box in the main entrance hall. How to complain was also detailed in the welcome pack for clients. Informal complaints were also raised at client led house meetings. Informal complaints were recorded in client meetings. Recent changes had been made, following informal complaints about the food and changes to TV times. However, one client commented that informal complaints had not been listened to, although we were unable to corroborate this.
- Clients were asked to complete service evaluation forms every six weeks. These were audited every three months to identify themes and opportunities to learn and improve. Complaints were discussed in staff meetings.

Are substance misuse services well-led?

Vision and values

- Longreach had a philosophy with a clear aim and objectives that were recovery focused and individual. All staff were aware of the philosophy and values. These were set out in the welcome pack to clients.

Good governance

- There was a clear organisational structure with defined responsibilities for governance and for accountability. The senior leadership team were actively involved in the service. Organisational risks were identified on a corporate risk register. This was graded and had control measures and was reviewed by the board of trustees.
- The provider reported to the national drug treatment monitoring system and was part of the clinical governance forum for Plymouth.

- Board meetings took place every two months and the venue rotated between the providers different sites, so that it took place at Longreach once every six months. Action from the multi-disciplinary meetings were escalated to the monthly senior management team meetings. We reviewed staff team minutes that confirmed information was disseminated to the staff team.
- The manager undertook a range of audits to monitor standards and identified areas of improvement. Staff members checked completed audits to ensure they were accurate.
- The systems for staff to receive regular supervision and appraisal and new staff received induction to prepare them for working within the service were robust and all staff was up to date with mandatory training.
- There was a system to ensure that shifts were covered by sufficient staff.
- There was part time administrative support that freed up time for counsellors and support workers to spend with clients.

Leadership, morale and staff engagement

- Staff felt very supported and valued by the manager. Morale was high with good staff engagement. The team were very positive and commented on how they felt supported by each other and their manager.
- Senior staff were supported to complete leadership and management courses.
- We were not made aware of any bullying or harassment and staff told us they knew how to whistle blow and would be comfortable to do this.

Commitment to quality improvement and innovation

- The manager was committed to quality improvement. For example, following research that demonstrated the impact of aftercare support on success rates the service had jointly set up more after care support. The Sunflower recovery project was a joint programme with another local women's substance misuse service. Lottery funding had been awarded and the service had started in early October 2016.
- The manager had also been successful in obtaining public health funding for a seven-bed female detoxification unit and was awaiting final approval on plans for the new detox suite, which included a new clinical room, new family room and garden room.
- There were plans to improve the large garden space with volunteer gardeners to lead on a project to create a cottage garden.

Outstanding practice and areas for improvement

Outstanding practice

The service had carried out a role reversal day recently where clients became staff and staff clients for the day. The team made improvements to their admission process because of this exercise in order to improve the client experience.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all medicines given to clients to self-administer have the legally required prescribing and dispensing information, including dose instructions and patient name.
- The provider must ensure that all missed doses of medication are explained and when necessary are followed up with the GP or specialist nurse for advice and guidance.

Action the provider SHOULD take to improve

- The provider should ensure that they complete notifications to CQC, including safeguarding.
- The provider should ensure that all staff undertake Mental Capacity Act training as part of their mandatory training programme.
- The provider should review its policy on not having lockable bedroom doors for clients.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not correctly carrying out safe administration of self-medication which was a breach of Regulation 12(2) (b) (g).