Brookdell House

Quality Report

Foreside
Barrowford
Lancashire
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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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

Overall summary

We rated Brookdell House as good because:

- The provider had developed a day care support service so that clients who made suitable progress could continue their treatment in the community.
- The provider recognised the benefits of exposure to community living and during the final month of treatment, clients had the opportunity for clients to attend the day care service. This offered clients information and support through visible recovery in the wider community.
- To develop more effective treatment within the residential setting, the provider offered 'sharing sessions' that gave clients opportunities to learn through the experiences of others who had completed treatment.
- The recovery programme was adapted to meet individual need by including, for example, additional one to one time or changing the timescale for completion. Clients set their own individual goals to develop their identified strengths and meet their needs. Individual work was linked to each client's progression through the recovery programme.
- Staff provided treatments and care for clients based on national guidance and best practice. Treatment interventions included cognitive behavioural therapy, family therapy and activities intended to help clients to develop personal responsibility and acquire independent living skills.
- Recovery plans included clear pathways to other supporting services. The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care.
- Staff actively engaged clients in planning their care and treatment. Clients reviewed their progress in personal development meetings with their keyworkers. Most clients had a risk management plan and recovery plan that demonstrated their preferences, recovery capital and goals.
- Successful treatment outcomes were above the national average.
- Staff supported clients with activities outside the service and to maintain contact with people that mattered to them.
- Staff were able to contribute to plans for the service. Managers promoted a positive culture. Staff felt respected, supported and valued, and the team worked well together.
- Cost improvements did not compromise client care. The provider had developed different methods of service delivery to ensure they could still meet clients' needs where funding was reduced.
- Managers had information about the performance of the service that helped them plan service developments.
- Clients had opportunities to give feedback on the service they received.

However:

- Not all identified client risk had been explored so the risk could be managed.
- Not all recovery plans set out clearly how clients would progress through the recovery programme, how their identified goals were linked to the programme and what support they needed to achieve their goals.
- Systems for assessing, monitoring and improving the quality and safety of the service did not ensure the provider had effective oversight of governance issues.
- Policies and procedures were not always regularly reviewed.
- There was no central record of care record audits, so managers did not have easy access to information about actions needed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	Brookdell House provides residential rehabilitation for opiate addiction and alcohol addiction to males and females over 18 years of age.

Summary of findings

Contents

Good

Location name here

Services we looked at
Substance misuse services

Summary of this inspection

Background to Brookdell House

Brookdell House is located in Barrowford in Lancashire, in two storey premises. The ground floor is accessible for clients with mobility needs. The service provides residential rehabilitation for opioid addiction and alcohol addiction to males and females over 18 years of age. There are 19 beds. At the time we inspected there were 14 clients.

Brookdell House admits clients from across the north west. Most clients are funded by statutory bodies.

The service is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse

This location has been registered with CQC since December 2017. It has not been inspected before.

There is a registered manager and a nominated individual.

Our inspection team

The team that inspected the service comprised two CQC inspectors and an assistant inspector.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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 location.

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for clients;
- observed one group therapy session;
- spoke with four clients who were using the service;
- spoke with the registered manager;
- spoke with two other staff members; including support staff and a manager
- received feedback about the service from three commissioners;
- reviewed notes from one hand-over meeting
- collected feedback from one client using comment cards;
- looked at three care and treatment records of clients:
- carried out a specific check of the medication management;
- reviewed two staff files, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

The clients we received feedback from were mostly positive about the service they received. They described it as excellent and highly organised. They said they found the staff compassionate and understanding, and always available. They said the group work and the counselling sessions helped them a lot, and felt the service was a safe place for recovery.

However, one client told us they felt it would be difficult to complain if they needed to because of the small staffing and managerial structure. They also raised concerns about staff being late for groups, disagreement about one to one sessions and house rules being overly restrictive. One client told us about an incident of breaching house rules that had led to them losing a 'life', which they were not happy about.

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?

Good

We rated safe as good because:

- The premises were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- There were enough staff to meet clients' needs. All staff had received training in key skills so that clients were kept safe.
- Risk assessments identified potential triggers and set out how to manage the risk.
- There was a protocol for unexpected exit from treatment that included who to contact and what action to take, such as access to the day care programme and signposting to other options.
- Therapeutic interventions were clinically justified to ensure clients remained focused on the recovery programme and to support them to overcome addiction in a therapeutic environment.
- Staff understood how to identify clients at risk of abuse.
- There was an open and transparent culture.

However:

- Clients' individual risks were not always identified. In one record, there was no evidence that an identified risk had been explored so the risk could be managed.
- A personal emergency evacuation plan was not signed or dated by the staff member who completed it.
- There was no review of therapeutic interventions.

Are services effective?

Good

We rated effective as good because:

- The provider had developed a day care support service so that clients who made suitable progress could continue their treatment in the community.
- The provider recognised the benefits of exposure to community living and during the final month of treatment, clients had the opportunity to attend the day care service. This offered clients information and support through visible recovery in the wider community.
- To further develop more effective treatment within the residential setting, the provider offered 'sharing sessions' that gave clients opportunities to learn through the experiences of others who had completed treatment.

Summary of this inspection

- Assessments considered physical and mental health needs and risks such as history of substance misuse or self-harm.
- The recovery programme was adapted to meet individual need by including, for example, additional one to one time or changing the timescale for completion. Clients set their own individual goals to develop their identified strengths and meet their needs.
- Treatment interventions included cognitive behavioural therapy, family therapy and activities intended to help clients to develop personal responsibility and acquire independent living skills.
- Staff received supervision and had and annual appraisal of their performance. Appraisals included conversations about how their development could be supported.
- Recovery plans included clear care pathways to other supporting services. The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care.

However:

- One recovery plan did not set out clearly how the client would progress through the recovery programme, how their identified goals were linked to the programme and what support they needed to achieve their goals.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with compassion and kindness and supported their individual needs**.**
- Staff actively engaged clients in planning their care and treatment.
- Clients reviewed their progress in personal development meetings with their keyworkers.
- Most clients had a risk management plan and a recovery plan that demonstrated their preferences, recovery capital and goals.
- Clients acted as peer mentors for new admissions, to help them settle in.
- Clients had opportunities to give feedback on the service they received.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- The service was accessible to all who needed it. Issues such as communication, cultural or dietary requirements were identified prior to admission to ensure clients' needs could be met.
- Risk management plans and recovery plans reflected individual needs, including clear care pathways to other supporting services.
- Staff planned for clients' discharge, including good liaison with care co-ordinators and accessing other services local to the client's home.
- Successful treatment outcomes were above the national average.
- Clients had their own rooms where they could keep personal belongings safely. There were quiet areas for privacy.
- Staff supported clients with activities outside the service and to maintain contact with people that mattered to them.
- Clients had been involved in local community activities.
- Staff understood how complaints and concerns were dealt with. There were external arrangements for investigating complaints if there was a conflict of interest.

Are services well-led?

Good

We rated well led as good because:

- The organisation had a clear definition of recovery that all staff shared and understood.
- Staff were able to contribute to plans for the service. Managers promoted a positive culture. Staff felt respected, supported and valued, and the team worked well together.
- There were team discussions that ensured that essential information was shared.
- Staff carried out clinical audits of care records and took appropriate action.
- Cost improvements did not compromise client care.
- Managers had access to information about the performance of the service that helped them plan service developments.
- Clients had opportunities to give feedback on the service they received.

However:

- Systems for assessing, monitoring and improving the quality and safety of the service did not ensure the provider had effective oversight.
- There was no central record of care record audits, so managers did not have easy access to information about actions needed.
- Policies and procedures were not always regularly reviewed.
- There was no review date for therapeutic interventions.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Clients consented to care and treatment on admission. The service did not admit clients who lacked capacity as they would not be able to engage with the recovery programme. If there were concerns about a client's capacity, the managers liaised with the client's care co-ordinator.

Staff supported clients to make decisions on their care for themselves. There was a policy on the Mental Capacity Act that staff were aware of and could refer to for guidance. They had completed training in and understood their responsibilities in relation to the Mental Capacity Act 2005.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Substance misuse services

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

Are substance misuse services safe?

Good

Safe and clean environment

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

Staff knew about ligature anchor points and actions to mitigate risks to clients who might try to harm themselves.

Bedrooms for male and female clients were located on different sides of the building. All bedrooms had a sink and there were adjacent bathrooms. Members of one sex did not have to pass through an area occupied by the other sex to reach toilets or bathrooms.

Safe staffing

The service had enough staff to meet clients' needs and was staffed 24 hours a day, seven days a week. Staff knew the clients well and received training to keep them safe from avoidable harm.

The service employed three counsellors, a social co-ordinator and five support staff. There was also a secretary and a finance manager.

No staff had left the service in the 12 months before this inspection and there were no vacancies. There had been a total of five days sickness overall. There were arrangements for managing staff shortages.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. For example, staff had completed fire training and first aid training.

Assessing and managing risk to clients and staff

We reviewed three sets of care records. Staff carried out a pre-admission assessment. They completed risk assessments for each client and used them to understand and manage risks individually. The risk assessments identified risks and potential triggers, and set out how to manage the risk. Clients were made aware of the risks of continued substance misuse and safety planning was included in recovery plans. Staff and clients updated the risk assessments at least monthly.

However, one record that we reviewed identified that, prior to admission, the client had participated in behaviours that potentially exposed them to harm. There was no evidence regarding when this had occurred or that this risk was explored further with the client so it could be managed appropriately. This meant that staff may not be fully aware of risks to or posed by the client and did not have guidance to help them to manage the risk.

The same record contained a personal emergency evacuation plan for the client but this was not signed or dated by the staff member who completed it.

The provider had a protocol for unexpected exit from treatment that included who to contact and what action staff should take. This included offering access to the day care programme as an alternative to residential treatment, and signposting to other options, such as mutual aid groups.

Staff did not use restrictive interventions such as physical restraint.

There were therapeutic interventions designed to create a safe environment conducive to community living. The therapeutic interventions set boundaries, defined the

house code of conduct and established an expectation that clients would be involved in the day to day running of the house. The rationale was to introduce structure and routine, to engender a culture of respect and trust, privacy, safety and personal responsibility and commitment, and to enable clients to develop a sense of value and self-respect.

The use of mobile phones, going out and having visitors were limited during the early weeks of treatment then reviewed as the client progressed through the programme.

Some therapeutic interventions, such as restricted access to sharp objects, were limited during the early weeks of recovery and individually risk assessed as the client progressed through the recovery programme.

There were other limits on, for example, playing music and television in communal areas or taking food and drink into bedrooms.

Clients understood and agreed to the therapeutic interventions before they were admitted. Details were set out in the client information pack. Breaching the interventions carried consequences that could eventually cumulate in discharge. This involved losing a 'life'. There was no process of appeal but clients could make a complaint. The team reviewed this after one month and if the client had made progress, the 'life' was given back. If a client lost three 'lives', the team considered whether it was appropriate for them to remain in the recovery programme.

The interventions were part of the therapeutic model. They were clinically justified by the need to ensure clients were not distracted from the recovery programme and to support them to overcome addiction in a therapeutic environment by managing and reducing behaviour that potentially exposed them to harm, and encouraging personal responsibility. They were set out in the client information pack but there was no date for review.

Safeguarding

Staff knew 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. They knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.

Staff access to essential information

Staff maintained a paper recording system. They kept detailed records of clients' ongoing care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Medicines management

No medicines were prescribed at the service. All medicines stored on site were prescribed externally. Staff completed annual medicine administration training. There was a policy that provided guidance for staff. The policy covered the ordering, storage and giving out of medications. However, the policy did not have a review date.

Clients could be assessed for self-administration of medicines. Safe self-administration was based on risk, motivation and independence, and taking account of the client's ability and dexterity to open the medicines.

Track record on safety

There were no serious incidents for this service reported 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 team. There was an independent consultant who could also investigate incidents if there was a conflict of interest.

There was an open and transparent culture. Staff understood that when things went wrong, they needed to apologise and give clients honest information and suitable support. There was a policy to provide guidance.

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

Good

Assessment of needs and planning of care

We reviewed three sets of care and treatment records.

The provider carried out a pre-admission assessment for all clients, which considered physical and mental health needs and risks such as history of substance misuse or self-harm.

All clients followed the 12-step recovery programme. The programme was adapted to meet individual need by including, for example, additional one to one time or changing the timescale for completing step work.

However, one record only contained a timetable of the 12-step recovery programme. The assessment identified treatment goals but there was no clear link between these goals and the recovery programme. This record did not contain an individual recovery plan that set out how the client would progress through the recovery programme, how their identified goals linked into it or what support they needed to achieve their goals. There had been two-weekly reviews but the reviews did not reflect how the client was progressing in achieving their goals. This meant that the provider could not demonstrate how they provided the support the client needed to achieve their goals.

As they progressed through the recovery programme, clients completed individual pieces of work and alongside it, with staff, they set their own individual goals to develop their identified strengths and meet their needs. They looked at what they wanted to achieve and how to do that, including considering issues that might block their progress, things that might be helpful, and how to build on their strengths. Individual needs and goals included, for example, anxiety about going out or speaking in groups, to modify feelings of anger, and accessing education. Staff and clients updated the goals at least monthly or when needed.

Best practice in treatment and care

Staff provided treatments and care for clients based on national guidance and best practice. Staff supported clients with their physical health and encouraged them to live healthier lives. On admission, clients were registered with a local GP, who carried out a physical health assessment, including testing for blood borne viruses where appropriate.

The recovery programme followed the 12-step model, supported by individual therapy sessions. The 12-step programme is a set of principles outlining an approach to recovery from addiction. The model focuses on interaction within a supportive group structure. The recovery programme was delivered via a structured timetable of group work, individual therapy time, which took place every two weeks, and individual assignments that helped clients identify their own needs and goals. Personal development meetings took place initially every day, progressing to at least weekly, fortnightly, then at least every month. The recovery programme continued through the weekend when it included social time and family visits.

Group work was client led and gave clients space to discuss how they were feeling. Clients offered each other support in the group when they were struggling. Individual work was carried out within the group, and was linked to each client's progression through the recovery programme.

Staff used motivational interviewing techniques to help clients to be clear about their own strengths and needs and understand their reasons for changing their behaviours.

Treatment interventions included group therapy, cognitive behavioural therapy and activities intended to help clients to develop personal responsibility and acquire living skills, such as budgeting, shopping, cooking and laundry. The service also offered family therapy.

Staff encouraged clients to live healthier lives through offering support, advice and information about behaviours, goals and future planning. This included education around healthy food choices, taking regular exercise and smoking cessation.

The provider had developed a day care support service. They reviewed clients' progress at around 10 weeks treatment, along with the client and their care co-ordinator. If the client had made suitable progress, they could transfer to the community and continue their treatment through the provider's day care support. This had been discussed and agreed with commissioners. Alternatively, if the client stayed on in the residential setting, they could access the day care support service following their discharge, at no additional cost.

As clients progressed through treatment, the provider recognised the necessity for exposure to community living. During the final month of treatment, the provider offered the opportunity for clients to attend the day care service for two days per week. This meant the client was amongst people who were moving forward in recovery, and offered them information and support through visible recovery in the wider community, in line with the Drug Strategy 2010 that sets out the government's approach to tackling drugs and addressing alcohol dependence through three themes, which include building recovery in communities.

Good

Substance misuse services

To further develop more effective treatment within the residential setting, the provider also offered opportunities to learn through the experiences of others who had completed treatment. This enabled clients to visibly connect to changes of others, identify areas of vulnerability in themselves so that they were able to address them whilst still receiving the support of the residential setting, consider things that may have worked or not worked, and reinforce the message of recovery to inspire and motivate clients still in treatment. This was facilitated through sharing sessions, where clients who had completed treatment were invited to speak with those still in treatment, either within a group or on a one-to-one basis.

Senior staff held reflective practice meetings every month staff where they discussed issues arising in the previous month, such as safeguarding, group dynamics and medicines. The issues were taken to team meetings that all staff attended. Learning from the issues included considering ways of promoting honesty and breaking down barriers between staff and clients. This involved, for example, supporting open discussion in community meetings.

Monitoring and comparing treatment outcomes

Staff regularly reviewed care and recovery plans with clients. They used treatment outcome profiles to monitor patients' progress.

The provider reported outcomes to the National Drug Treatment Monitoring Service, which collates data on substance use.

As of 31 January 2019, 86 clients had started treatment within the previous year; 67 for alcohol, 16 for opiates, three for opiates and alcohol. Of those, 42 (49%) had completed treatment successfully; 31 for alcohol (55% compared with the national average of 31%), eight for opiates (50% compared with the national average of 6%), three for opiates and alcohol (100%). Fourteen (16%) were still in treatment. The remaining 30 did not complete treatment.

Skilled staff to deliver care

Managers supported staff with appraisals and supervision. All staff had had an appraisal in the 12 months before this inspection. Staff received supervision at least every eight weeks. All were up to date. Managers identified staffs' learning needs and offered opportunities to update and develop their skills and knowledge. This ensured staff had the skills they needed.

Team meetings took place every month. Discussions included, for example, safeguarding and conflict between clients. Matters raised were updated at the following meeting.

All staff working directly with clients had completed training such as person centred counselling, health and social care, counselling concepts, alternative therapies and medicines training, and received clinical supervision.

Multi-disciplinary and inter-agency team work

Staff worked together as a team to benefit clients. They supported each other and liaised with other agencies to make sure clients had no gaps in their care.

There was a handover meeting at every shift change that included information about each client. There were some gaps in this record, but staff also completed a separate daily record for each client.

Every three months, staff reviewed clients' progress at a meeting with their care co-ordinator.

Recovery plans included clear care pathways to other supporting services. The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care.

The service discharged clients when specialist care was no longer necessary and worked with relevant supporting services to ensure the timely transfer of information.

Good practice in applying the MCA

Clients consented to care and treatment on admission. The service did not admit clients who lacked capacity as they would not be able to engage with the recovery programme. If there were concerns about a client's capacity, the managers liaised with the client's care co-ordinator.

Staff supported clients to make decisions on their care and treatment for themselves. There was a policy on the Mental Capacity Act that staff were aware of and could refer to for guidance. They had completed training in and understood their responsibilities in relation to the Mental Capacity Act 2005.

Good

Substance misuse services

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We received feedback from clients that was mostly positive about the service they received. They described service as excellent and highly organised. They said staff were compassionate and understanding, and always available. They felt the service was a safe place for recovery.

However, one client told us they felt it would be difficult to complain if they needed to because of the small structure. They also raised concerns about staff being late for groups, disagreement about one to one sessions and house rules being overly restrictive. One client told us about an incident of breaching house rules that had led to them losing a 'life', which they were not happy about.

Staff supported clients to understand and manage their care, treatment or condition.

They directed clients to other services when appropriate and they supported them to access those services.

The service had a clear confidentiality policy that staff understood. Staff maintained the confidentiality of information about clients.

Involvement in care

Staff involved clients and those close to them in decisions about their care, treatment and changes to the service.

Staff communicated with clients so that they understood their care and treatment, including finding effective ways to communicate with clients with communication difficulties. Communication issues were identified during the pre-admission assessment.

Clients reviewed their progress in personal development meetings with their keyworkers.

Each client had a recovery plan and risk management plan that demonstrated their preferences, recovery capital and goals. Staff actively engaged clients in planning their care and treatment.

Clients acted as peer mentors for new admissions, to help them settle in. They had opportunities to give feedback on the service via weekly house meetings, comment boxes and questionnaires at the end of treatment.

Families and carers could visit their relative and could provide feedback via a questionnaire. The service could refer them to external organisations for support with carer's assessments, for example.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Clients were admitted from the north west region. The service was available to clients when they needed it. There were clearly documented admission criteria. All admissions were planned.

The service was able to see urgent referrals quickly if needed; however, clients were usually referred via community services. They completed pre-admission work in the community then went on to detoxification, before being admitted for rehabilitation. This helped ensure clients' needs could be met and they were prepared for the rehabilitation process. Potential clients also visited a minimum of three services before deciding where they would prefer to receive treatment.

The service had alternative care pathways and referral systems for clients whose needs could not be met by the service. There were links with community based substance misuse services.

Risk management plans and recovery plans reflected individual needs, including clear care pathways to other supporting service, such as mutual aid groups and community groups.

Staff planned for clients' discharge, including good liaison with care co-ordinators.

Care records contained plans for discharge that included accessing other services local to the client's home.

Good

Substance misuse services

Staff supported clients during referrals and transfers between services, for example, if they transferred to the day care support service.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had their own rooms where they could keep personal belongings safely. There were quiet areas for privacy and where clients could be independent of staff. There was a payphone that clients could use.

Clients had access to drinks and snacks but could not take them into their bedrooms or into group sessions.

Clients were not expected to sleep in dormitories, although some bedrooms were shared. Sharing was between clients of the same gender. Sharing was part of the rehabilitation model and was planned so that clients could offer each other support and did not isolate themselves.

Clients' engagement with the wider community

Staff supported clients with activities outside the service, such as voluntary work, education and family relationships. They supported clients to maintain contact with their families and carers, and encouraged them to develop and maintain relationships with people that mattered to them. There were links with a local college and gym.

The provider encouraged access to the local community and activities. Clients had been involved in community improvement activities with a local group.

Meeting the needs of all people who use the service

The service was accessible to all who needed it and took account of clients' individual needs. Staff helped clients with communication and cultural support.

There were accessible rooms to see clients in for group work and individually. There was one en suite accessible bedroom on the ground floor.

Issues such as communication, cultural or dietary requirements were identified prior to admission to ensure clients' needs could be met. The service had facilitated visits to a local church.

Listening to and learning from concerns and complaints

There were no complaints in the 12 months prior to this inspection. The service had a complaints procedure, which was shared with all clients. The complaints policy explained how complaints were managed and lessons learnt and acted upon to improve the quality of the service. It explained that clients could complain directly to their care co-ordinator if they wished.

Staff we spoke with understood how complaints and concerns would be treated. There were external arrangements for investigating complaints if there was a conflict of interest.

Are substance misuse services well-led?

Good

Leadership

Managers had the right skills and abilities to run a service providing sustainable care. They had the skills, knowledge and experience to perform their roles and a good understanding of the service. They could explain clearly how the teams were working to provide care, they were visible in the service and approachable for clients and staff.

The organisation had a clear definition of recovery that was shared and understood by all staff.

Vision and strategy

The service aim was to support and empower clients ongoing abstinence from drug and alcohol dependency, and help them explore opportunities for personal growth and development. This was achieved with involvement from staff, clients, and groups representing the local community.

Staff knew and understood the service vision and values, and they could explain how they were working to deliver care within the budgets available. They had opportunities to contribute to discussions about plans for the service, especially where the service was changing.

Culture

Managers promoted a positive culture. Staff felt respected, supported and valued. Appraisals included conversations about their development and how it could be supported.

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

Governance

Good

Substance misuse services

There were systems and procedures to ensure, for example, that the service was safe and clean, that there were enough staff, that staff were trained and supervised, that clients were assessed and treated well, that essential information was shared and that admissions and discharges were planned.

Policies and procedures were not always regularly reviewed. Some contained guidance that was generic and not specific to the service.

Discussion in team meetings ensured that essential information, such as learning from incidents and complaints, was shared and discussed.

Staff understood the arrangements for working with other organisations to meet clients' needs.

Staff undertook clinical audits of care records. However, the audit of each record was stored in the record. One record did not contain an audit. There was no central record, so while the audits were sufficient to provide assurance and staff acted on the results when needed, they were not easily accessible to managers.

There was no review of therapeutic interventions.

This meant that systems for assessing, monitoring and improving the quality and safety of the service did not ensure the provider had effective oversight of governance issues.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a risk register and staff could escalate concerns when required.

The provider had developed day care support in response to commissioning decisions relating to funding for residential treatment.

Information management

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.

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

Staff made notifications to external bodies as needed.

Engagement

Staff and clients had access to up-to-date information about the provider's work and the services they used.

Clients had opportunities to give feedback on the service they received in a manner that reflected their individual needs.

Managers engaged with external stakeholders such as commissioners.

Learning, continuous improvement and innovation

The service assessed quality and sustainability impact of changes, including financial. The provider had developed different methods of service delivery to ensure they could still meet clients' needs where funding was reduced.

All staff had objectives focused on improvement and learning.

Outstanding practice and areas for improvement

Outstanding practice

The provider had developed a day care support service. If a client had made suitable progress, they could transfer to the community and continue their treatment through the provider's day care support.

Alternatively, if the client stayed on in the residential setting, they could access the day care support service following their discharge at no additional cost.

As clients progressed through treatment, the provider offered the opportunity for clients to attend the day care service for two days per week.

This meant clients were amongst people who were moving forward in recovery, and offered them information and support through visible recovery in the wider community, in line with the Drug Strategy 2010.

To further develop more effective treatment within the residential setting, the provider also offered opportunities to learn through the experiences of others who had completed treatment. This was facilitated through sharing sessions, where clients who had completed treatment were invited to speak with those still in treatment, either within a group or on a one-to-one basis.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all identified client risks are explored so the risk is managed appropriately.
- The provider should ensure that all recovery plans are signed and dated.
- The provider should ensure that all recovery plans set out clearly how clients will progress through the recovery programme, how their identified goals are linked to the recovery programme and what support they need to achieve their goals.
- The provider should ensure that therapeutic interventions are reviewed regularly with clients.
- The provider should ensure that systems for assessing, monitoring and improving the quality and safety of the service ensure the provider has effective oversight of governance issues.
- The provider should ensure that all policies and procedures are reviewed regularly and are specific to the service.