Assisi Community Care Limited - Francis House

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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 do not currently rate independent standalone substance misuse services.

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

- Francis House did not provide a clear model of care that met all the needs of the male clients using the service. The service was registered to provide accommodation for clients who needed residential and personal care and clients who were recovering from substance abuse.
- Most of the clients had lived at Francis House for a number of years. Some as they were getting older were experiencing a reduction in their mobility and memory loss. For these clients there were concerns that the lack of night time staffing and the environment of the home was potentially unsafe and did not meet their needs.
- Others were accessing the service for a shorter period as part of their recovery from substance misuse. For these clients we did not see a structured programme in line with best practice to support their recovery. In addition, there was not a clear programme of rehabilitation to prepare clients for greater independence.
- Medication was secondary dispensed which meant that clients did not always see medicines in their original pack. This could have led to accidental errors. The service took immediate action to change their processes and we received confirmation that this had taken place following the inspection.
- There were conflicts of interest if staff needed to report concerns or investigate complaints or incidents due to family members both running and working in the service. A freelance consultant in health and social care, who provided additional governance and support, was available but at the time of the inspection, there was not yet evidence that it was not always sufficient or timely.
- The registered manager, whilst living on site was not well enough to participate in the inspection or be interviewed. The provider had not notified the CQC of the providers' health problems.

However:

- Clients were treated with kindness and staff were caring.
- Morale was high amongst the staff team and staff were enthusiastic about their roles. Staff all described good support from the assistant manager.
- Francis House supported long-term clients education and learning with outside organisations. For example, one client had completed a fine arts degree and others had attended further and higher education courses.
- Clients had up to date care plans and clients felt involved in their care, this included some client's wishes not to be involved in groups that the service offered.
- Systems were in place to ensure regular mandatory training and supervision. Staff were trained and demonstrated an understanding of the Mental Capacity Act.
- Most clients were very positive about the service and felt that staff consistently treated them with respect and dignity.

Summary of findings

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Background to Assisi Community Care Limited - Francis House

Assisi Community Care Limited is a CQC registered provider, offering residential rehabilitation and support services for men recovering from substance misuse. Assisi Community Care Limited consists of one registered location, Francis House. The service includes Clare House which has the accommodation facility. The adjacent buildings are set within extensive grounds in a rural setting in North Devon.

Francis House is a family run organisation and the owners live on site in neighbouring accommodation. They describe themselves as a Christian centred organisation. The service is registered as a 40-bed rehabilitation service for men but currently runs from a smaller building on the premises and admits a maximum of 18 male clients at any one time. There were 11 clients at the time of our inspection. The minimum stay is usually three to six months. A number of men were long-term residents who had lived there for many years.

Local authorities across England and Wales funded the majority of clients.

The service is registered by the CQC to provide the following services:

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

The service had a registered a manager and a nominated individual.

The location had been inspected three times since its registration in 2010. At the last inspection in 2013, the location was meeting all the required standards. This is the first inspection of the service under the new provider using the Health and Social Care Act (regulated activities) regulations 2014.

Our inspection team

The team that inspected the service was led by a CQC inspector, a CQC assistant inspector and a specialist advisor who was a specialist clinician 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?

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:

- looked at the quality of the physical environment, including some of the bedrooms in Clare House where clients slept
- observed how staff were caring for clients
- spoke with seven clients
- spoke with the nominated individual on behalf of the registered manager
- spoke with the medicines lead for the service
- spoke with five other staff members employed by the service provider, including recovery workers and the administrator
- received feedback about the service from the local Healthwatch, local health services, and commissioners and care managers.
- spoke with two family members and next of kin of current and one former client
- observed two groups
- collected feedback using comment cards from 12 clients
- looked at six client care and treatment records, including medicines records
- reviewed six staff records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Most clients that we spoke with very satisfied with the service. Clients told us that they received very good care and were supported with their individual needs. They told us that staff treated them with dignity and respect.

Clients described staff as friendly and caring. One client said that staff were like friends to him. However, one client thought that staff did not listen to concerns raised.

Clients were mainly satisfied with the activities and they chose whether to attend. However, one person told us that there was not enough to do and another said staff were often too busy to support social activities.

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:

- Staff were secondary dispensing client's medication. Staff were removing medicines from their original pack, which could have led to accidental mix-ups and errors. The service took action to change their process during the inspection.
- As the clients were becoming older there were increasing potential safety risks for people using this service. There were no staff at night and some clients smoked in their rooms, which meant there were fire risks. Some had mobility issues, which meant there was a risk of falls and staff not being available to help. The environment of the home and grounds did not meet the needs of people with mobility problems.
- There was a lack of contingency planning to cover staff sickness. Staff we spoke to said they sometimes felt pressured to work when others were off sick or on leave.

However:

- There were no vacant staff positions.
- Mandatory training records were up to date for all staff.
- The service had a culture of reporting and sharing learning from incidents.

Are services effective?

We do not currently rate standalone substance misuse services.

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

- For clients with a history of substance abuse the service was not operating an evidence based structured programme to support their recovery.
- The service did not provide an active evidenced based rehabilitation and recovery programme and most clients were not being prepared for greater independence and discharge.

However:

- Most clients we spoke with did not want to follow an active rehabilitation and recovery programme and this was reflected in care plans.

Summary of this inspection

- Care plans were personalised and individual and regularly reviewed by staff.
- There was evidence of ongoing physical health monitoring and harm reduction, such as staff supporting clients to attend smoking cessation clinics.
- Keyworkers met with clients on a one to one basis each day and updated care managers and other external staff.
- Staff were trained in and demonstrated an understanding of the Mental Capacity Act.

Are services caring?

We do not currently rate standalone substance misuse services.

- Most clients were very positive about the service.
- Staff had created an atmosphere where clients felt respected and treated with dignity.
- Clients were involved in their care and were able to involve their families and significant others in their care. Families and friends were very satisfied with the care and involvement.

However:

- One client reported feeling bored and thought that staff did not always have time to listen.

Are services responsive?

We do not currently rate standalone substance misuse services.

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

- Discharge planning and exit plans were not always in place.
- Some clients did not think there was enough to do or enough opportunity to visit the local community.
- One client did not think complaints were listened to.

However:

- There was a full range of rooms to promote recovery, such as therapy rooms, snooker rooms, a multi faith room and a gym although these were all underutilised.
- Staff and clients were aware of the complaints process. Staff and clients received feedback on the outcome of complaints and changes were made where appropriate.

Are services well-led?

We do not currently rate standalone substance misuse services.

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

Summary of this inspection

- The service did not have a clear purpose to meet the varying needs of the short and long term clients in residence.
- During the inspection the manager was not well enough to attend the inspection. The provider had not ensured the registered manager was able to undertake the role or notified any ill health to the CQC.
- There were conflicts of interest for staff if they needed to report concerns due to family members both running and working in the service. The service employed a freelance consultant to reduce the conflict of interest but this had not had an impact on recent incident and complaint investigations.

However:

- Systems were in place to ensure regular mandatory training, supervision and appraisals took place.
- Morale was good and staff felt well supported by the assistant manager.
- The service supported learning for staff and clients. Some clients had undertaken higher education courses, such as a fine arts degree.

Detailed findings from this inspection

Mental Health Act responsibilities

The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health was to deteriorate, staff were aware of whom to contact.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff demonstrated an awareness and understanding of mental capacity. Staff had completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- Francis House comprised of three adjacent houses. The accommodation facility at Clare House had bedrooms, bathrooms and kitchenettes for clients over two floors. There was accommodation on the ground floor of Clare House for clients with mobility needs. However, the route to the dining room and lounge in the adjacent building was not fully accessible without support. We witnessed a client with mobility needs using a radiator to hold on to, as there was no accessible grab rail. We reported to the assistant manager at the time of the inspection who told us that they would rectify this.
- Bedrooms, bathrooms and communal areas were cleaned regularly and this was recorded on cleaning checklists. However, clients reported that bathrooms and toilets were not always clean. The service had an infection control lead and all staff were trained in infection control.
- An environmental food premises inspection had given the kitchen a five star rating in 2016.
- The service undertook regular environmental checks for fire, water and electrical testing and these were up to date. All fire equipment had visible stickers to show they had been regularly checked and the service had a designated fire officer. There was a full time administrator employed at the service who carried out health and safety checks. However, checks did not include the paths between the buildings that were uneven in places and a risk for clients with mobility problems in particular. One client commented that the paths were unsafe and a potential hazard, another client commented that they had slipped on the path recently.
- Bedrooms and communal areas were homely and therefore not ligature free. Ligature points were adequately mitigated through the pre assessment process. A ligature pointwas defined as anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. People who were at risk of self-harm, such as using ligatures were not admitted, as the environment was not appropriate to accommodate people with this level of risk.

Safe staffing

- The service had a small team of nine full time staff and two managers. During the inspection, we were unable to speak to the registered manager due to sickness. We spoke to the nominated individual who was the assistant manager responsible for the day-to-day running of the service.
- Shifts were covered by two staff members and one manager from 8am until 6pm. There was one carer on duty up until 10pm at night. The service also employed one administrator, cook and maintenance person.
- The service was not staffed overnight and there was an on-call system shared between the registered manager and assistant manager who lived on site. The managers were on call from 6pm and there was an on call rota at night until 8am. However, the registered manager was off sick and the on call rota had not been updated to reflect this. We were told that this could be shared with a care worker who also lived on site if needed. Clients were aware of the system and we were told this was rarely used.
- The assistant manager advised that managers would stay later if any problems arose during the day or evening. However, there was a risk that clients may not be able to use the phone in an emergency. For example, one client had memory problems and another client needed assistance with their mobility. One client told us that they did not think the staffing was safe at night.

- Sickness in the year to July 2016 was 7%. Sickness and annual leave were covered by staff working additional shifts. The duty roster confirmed that staffing levels were maintained. However, staff told us that staffing could be pressured when there was sickness or staff on leave. If there was a longer period of leave, we were advised that agency staff would be used. The manager had recently revised their emergency plan to include staff recruitment & staffing levels that included actions they would take to ensure adequate staffing. There were no current vacancies.
- A training record was kept and staff were up to date with all mandatory training required for their role. This included fire safety, manual handling, health and safety, infection control, mental capacity act and medicines management. All staff had received recent safeguarding of vulnerable adults training and one staff member was trained in safeguarding children.

Assessing and managing risk to clients and staff

- All clients had been risk assessed prior to admission. Each client had a risk assessment that was up to date. However, risk assessments were brief and did not always have a recovery focus, such as evidence of positive risk taking. The assessment prior to admission was not always robust. One client had been risk assessed prior to admission and had greater physical health needs than had been identified on the preadmission risk assessment, which meant that there was a risk that they could not manage client needs. Risks were discussed at weekly team meetings and we were informed that risks were discussed in daily one to one key worker meetings. However, this was not always recorded. Risk plans and procedures were not robust enough to manage and mitigate foreseeable safety risks, such as uneven pathways and additional support for clients with memory and with mobility problems.
- All care staff were trained in medicines management. Medicines were stored in a locked medicines trolley in a locked clinic room. Medicines were delivered weekly by a local pharmacist. However, staff delivered medicines to some clients to take themselves without any prescribing or dose information. Medication was outside of the original packaging so clients could not see the instructions. This was secondary dispensing which could lead to medication errors. This was reported to the medicines lead and they immediately raised this with the manager to alter the service's policy and practice. We received confirmation after the inspection that changes had been made to improve medication administration.
- No clients were being prescribed controlled drugs at the time of our inspection. The service had facilities to store controlled drugs securely. However, there was an out of date controlled medicine locked in the controlled drugs cupboard. We reported this to the medicines lead, who arranged for the safe collection of this medicine from the local pharmacy.
- The premises were smoke free and there was an outdoor smoking shelter. However, we were advised that there was an exemption for clients who had opted to have bedrooms that were not smoke free. Most clients smoked in their bedrooms. The assistant manager stated that the service complied with the law as clients had signed a written agreement that agreed to comply with the smoke free law 2007, which included only smoking in designated areas, such as personal rooms. There were smoke alarms in corridors and all communal areas. Bedrooms where client smoked were not supervised at night, which was a fire risk as there were no staff to raise the alarm if there was a fire related incident.

Track record on safety

- The provider reported no serious incidents requiring investigation in the 12 months prior to August 2016.

Reporting incidents and learning from when things go wrong

- The provider had an accident and incident reporting policy. Staff we spoke to were aware of the incident and accident policy and routinely reported incidents.
- The provider notified the Care Quality Commission of serious incidents. We reviewed evidence of incidents shared and lessons learned shared with the team in staff meetings and during personal supervision.

Duty of candour

- Duty of candour is a legal requirement, which means providers must be open and transparent with clients

about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff were aware of the need to be open and transparent when things went wrong.

- However, we were told that incidents involving a member of staff who was part of the central family, could be investigated by another family staff member. This was a conflict of interest.

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)

- We reviewed six care plans and saw that each client had an assessment of their care needs that included consent and capacity. Care plans were up to date and regularly reviewed. Care plans were mainly individual and client focused. For example, one client had been supported to undertake a fine arts degree. Although care plans were individual, they did not have a clear recovery focus towards greater independence and rehabilitation. Many clients had lived at Francis House for a number of years, viewed the location as their home, and did not want to receive recovery-focused support.
- Each client was registered with the GP and physical health care was the responsibility of the GP. We saw evidence of on going physical health monitoring such as staff recording clients' weight. Clients care plans also showed input from physiotherapy and a diabetes nurse specialist. Chiropody was provided regularly and there were effective links with the service. There were visiting staff such as pharmacy, physiotherapy and chiropody and contact with care managers.
- Clients were supported to reduce or stop smoking and staff enabled clients to attend local smoking cessation groups at the GP surgery.
- Clients were supported to attend local meetings, such as alcoholics anonymous.
- Clients received annual reviews from their local authority care manager.

Best practice in treatment and care

- The service offered counselling and support with personal care but did not offer a structured therapeutic recovery programme based on an established evidence based approach and outcomes. A timetable of groups and activities was offered and clients could choose whether to attend. Activities included art groups and walking groups. Groups had a low attendance.
- The service whilst providing recovery groups did not provide a structured programme of rehabilitation with clear outcomes for people leaving the service. We observed two groups, which were attended by two clients. The recovery group did not follow recovery principles, which meant that opportunities could be missed for working towards recovery and independence. The art group was an activity group and did not have a therapeutic or recovery focus.
- We received feedback from stakeholders that the service did not always work with clients towards greater independence and recovery. The service described their programme of rehabilitation as holistic and individual. However, this did not follow guidance recommended by the National Institute for Health and Care Excellence (NICE), to actively engage in recovery-orientated treatment systems that aimed for clients to leave treatment, free of their dependence. The lack of recovery focus in groups meant that clients might not be equipped with the skills and resources they needed to leave the service and maintain their recovery independently. However, some clients had lived at the service for a long time and did not want to engage in an active recovery programme.
- There were regular audits such as audits of medication charts and infection control.

Skilled staff to deliver care

- Staff were experienced and qualified in health and social care. Three staff members were trained counsellors accredited by the British Association for Counselling and Psychotherapy. None of staff had nursing qualifications.
- Staff had received an appropriate induction to support clients at with health and social care needs.
- Staff were supervised regularly and felt well supported. There were regular staff meetings and up to date policies and procedures in relation to supervision and appraisal. External supervision was privately arranged

for one staff member. However, one staff member had been supervised by another family member, which could cause a potential conflict. The provider was aware of this and had made arrangements for supervision to take place with a new member of senior care staff.

- All staff had up to date appraisals. Staff kept up to date with reading updated policies and signed a declaration that they had done so.
- Staff received training for their role including an external consultant who provided additional training and support.

Multidisciplinary and inter-agency team work

- There were weekly team meetings and daily handovers. Handovers with the team included discussions of risks.
- Most client admissions were from outside of the local area. Clients received annual review visits from their health or social care manager who reported good communication with Francis House. However, there were concerns that agreements were not always actioned. For example, a request to provide a more recovery orientated care plan for a client had not taken place.
- The service reported that they liaised with local crises team and community mental health services on an individual basis for clients when needed.

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

- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training was mandatory for staff. Records confirmed that all staff had undertaken Mental Capacity Act training. Two staff had received training in DoLS.
- Clients had to consent to admission to the service. Staff demonstrated an awareness of capacity; such as if a client's capacity appeared to change.

Equality and human rights

- Staff received training in the Equality and Human Rights Act so that clients with protected characteristics were supported under the 2010 Equalities Act. Clients told us that they were supported irrespective of their race, religion or sexuality. There were ground floor bedrooms and communal areas so that clients with disabilities could have equal access. However, one client was restricted at the time of our inspection as the communal areas were not fully accessible.

Management of transition arrangements, referral and discharge

- The service accepted clients straight from home or from other services. Francis House worked with commissioners to manage referrals and plan discharges. However, there were two concerns raised by commissioners that discharge was not always coordinated well between the service and the on-going team. Concerns were also raised about the lack of exit planning for clients, for example, when a client left the service early the community services were not informed until the client had left which meant that community service support was not in place in a timely way.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Clients we spoke with at Francis House spoke highly of the care they received. We received comments cards from all the clients that confirmed this. Staff were described as caring, friendly and trustworthy. One former client told us that their recent stay had been a very positive experience. Relatives confirmed that staff were supportive and understanding.
- We observed a mutually respectful atmosphere at Francis House and saw staff knock on bedroom doors before entering clients' rooms.
- Most of the clients told us they felt safe at Francis House. However, one person said they did not always feel safe at night when there were no staff in the building.

The involvement of clients in the care they receive

- Clients were mainly very positive about the care they received. Clients we spoke with told us that they were as involved in their care as they wanted to be. However, one client told us that they did not feel that staff listened to their views.
- Key workers had daily morning meetings with clients. There was evidence of client involvement in their care plans and clients were offered a copy of their care plan.

Substance misuse services

- The service involved clients' relatives in their care, we spoke to two families who confirmed this and felt involved and included in their relatives care.
- There were regular satisfaction surveys carried out three times a year and feedback was displayed on the client noticeboard. There were weekly meetings with clients to discuss the running of the service and minutes were displayed

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Access and discharge

- The service had reduced their bed numbers to 18 and had 11 clients at the time of inspection. Some clients stayed at the service on a short-term basis of three to six months and some clients were long-term residents and had been at Francis House for more than ten years. Some clients were not in active recovery and many were long-term clients. The longest length of stay was 25 years. There had been eight discharges in the 12 months up to August 2016.
- Eight clients were on out of area placements. The service kept in touch with care managers through interim reports for short stay clients and six month and annual reviews for longer term clients. Discharge summaries were sent to the clients' GPs and care managers.
- Clients were required to abstain from alcohol and had completed alcohol detoxification. Clients signed a contract on admission to agree to abstain from alcohol and were aware of the contract prior to admission.
- There was no evidence of exit planning for clients who left the service early. Two stakeholders reported a lack of communication with discharge planning between the service and the on-going team, such as when clients left the service early.

The facilities promote recovery, comfort, dignity and confidentiality

- There was range of rooms to support treatment and care. Art and music therapy took place in activity rooms, an on-site gym and two snooker rooms were available for clients. A communal dining room and the kitchen had been recently refurbished. The communal conservatory was laid out with armchairs and a log burner.
- Despite the facilities, the communal spaces were underutilised. Clients told us they mostly chose not to use communal spaces or attend groups. Most clients were satisfied with this. However, two clients told us that there was not enough activity particularly at weekends. One client told us that he found it boring and that there was little to do.
- The service was located in a very geographically isolated area with no local amenities. A client told us that opportunities to go out to the community were limited to Wednesdays and Fridays when transport was available and said that this was not enough.
- Some furnishings were tired in appearance. However, the service was in the process of improving the social areas and developing new therapy and craft spaces and a staff office that was closer to the accommodation block and dining area.
- Bedrooms, bathrooms and kitchenettes for clients were over two floors in the accommodation block. There was accommodation on the ground floor for clients with mobility needs.
- There were spaces where clients could make phone calls in private.
- There was good access to outside space with large gardens and grounds in a rural setting.
- The food was prepared on the premises. There were client kitchens on each floor where clients could access hot drinks and snacks, such as fruit and yoghurts.
- Clients were able to personalise their bedrooms and rooms had lockable cupboards to store possessions.

Meeting the needs of all clients

- Whilst adjustments had been made for disabled access such as ground floor bedroom and bathroom facilities and communal spaces that were accessible via a ramp, the internal and external environment was not fully safe for people with mobility difficulties. For example we saw a client struggling to safely move around the inside of the home and we were told by clients about the risks of walking around the external areas.

- There was information available on how to complain and information was displayed about treatments and local services.
- There was a choice of food to meet the client's religious, cultural and medical needs, such as diabetic diets.
- Francis House was a Christian based organisation and had a Christian ethos and its own chapel. Clients were not required to be Christian but were asked to sign a contract to agree not to bring anti-Christian literature into the service. The on-site chapel was used as a multi faith room for clients of all religious denominations.

Listening to and learning from concerns and complaints

- There was one reported complaint within the year before the inspection. Clients said they were aware of how to raise concerns and complaints. Most clients felt that these were listened to and acted on.
- There were opportunities for clients to comment, complain, and make suggestions. Informal complaints were received through one to one meetings with keyworkers and weekly client meetings with staff. We were given examples where informal complaints were acted on and staff took action to rectify, for example in relation to food changes to the menu and size of the television screen. Both informal complaints were rectified with changes to the menu and the service purchased a larger television screen. However, one person said that they did not feel listened to despite the processes that were in place.
- There was a formal complaints procedure and clients and staff said they were aware of it. Complaints were acknowledged within three working days and investigated within a month wherever possible. We reviewed one complaint that had been investigated by the service within the timeframes set out in their policy. The actions included an investigation and evidence of improvements made and learning shared with the team though a complaints action plan. However, the investigator and the staff member involved in the complaint were family members and that was a conflict of interest. Whilst the provider has put in arrangements for an independent person to investigate complaints this has not yet been put into practise with complaints.

Are substance misuse services well-led?

Vision and values

- Francis house described its service as a Christian based house that offered short and long term stays for counselling rehabilitation and support for clients recovering from alcohol misuse. Staff and clients were able to tell us about this philosophy of the service.
- Francis house did not have a clear model of care to meet the needs of the range of clients. This meant that longer-term clients were receiving residential care, but without the staffing and support at night. This was a risk and did not meet the needs of the ageing residential group. Shorter-term clients did not have clear rehabilitation goals to support clients in their move to greater independence.

Good governance

- Systems were in place to ensure that the service was operating appropriately such as the monitoring of mandatory training, complaints and incidents. A freelance social care consultant supported the governance process and attended the governance meetings. Information and learning from the governance meetings was disseminated via staff meetings.
- Risks were discussed at governance and board meetings and these fed into staff meetings. However, the governance processes were not clearly monitoring the outcomes for clients using the service to ascertain whether the care and treatment being received was enabling them to make progress.

Leadership, morale and staff engagement

- The registered manager and joint owner was not present at the inspection due to ill health. We were not informed about this prior to this announced inspection. A notification had not been sent to the CQC.
- Morale amongst the staff team was good and staff were positive about the leadership from the assistant manager who was a joint owner.
- Staff enjoyed working at Francis house and felt the service gave high quality care. All the staff we spoke with were enthusiastic about the service. Senior staff described opportunities for development in their roles.

Substance misuse services

- Staff told us they knew how to whistleblow. We were not made aware of any bullying or harassment from staff. However, there was an inherent risk of conflict of interest as family members were working in and managing the service and it was therefore difficult to raise concerns and whistleblow.
- Staff described receiving good support from the assistant manager and had opportunity to input in the service development.
- Staff had access to the service's policies as well as national guidance documents kept in the staff office.

Commitment to quality improvement and innovation

- Staff supported clients to pursue interests such as art and education, including higher education courses. For example, one long stay client had completed a fine arts degree during his stay at Francis house.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is a clear model of rehabilitation that ensures client rehabilitation needs are fully met and that care is delivered in line with best practice.
- The provider must ensure that the staffing levels are safe at all times, including at night.
- The provider must ensure that the physical environment is suitable to meet the risks of the client group, such as reduced mobility and memory and other factors associated with the ageing client group.
- The provider must ensure that that all medicines given to clients have the legally required prescribing and dispensing information, including dose instructions and patient name.

Action the provider SHOULD take to improve

- The provider should ensure that transparent systems are in place to ensure that the there is no conflict of interest caused by family members working in the service.
- The provider should ensure that the service is meeting the requirements relating to registered managers, such as ensuring the registered manager is fit to manage the carrying on of regulated activities.
- The provider should ensure that CQC are informed through a formal notification when the Registered Manager is absent and unable to carry on duties relating to the regulated activities for more than 28 days.

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 nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA 2008: (Regulated Activities) Regulations 2014 Person-centred care** **9(1)(b)** The lack of clear model of rehabilitation meant that some client needs were not met and that care was not delivered in line with best practice. This was a breach of regulation 9. (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA 2008: (Regulated Activities) Regulations 2014 Person-centred care** **9(1)(b)** Care and treatment of service users was not appropriate to meet individual needs and did not reflect the increasing needs of the client group associated with ageing. This was a breach of regulation 9. (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.** Staffing support was not sufficient at night to ensure that clients were safe at all times. The environment was unsafe particularly for to use for clients with restricted mobility and other factors associated with the ageing client group. This was a breach of Regulation 12 (1)(2) (b),(d).

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The provider was not correctly carrying out safe administration of medication.

This was a breach of Regulation 12 (1)(2) (g).