# Turning Point - Leigh Bank Rehabilitation

## 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 | 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.

# Summary of findings

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 rated Leigh Bank Rehabilitation as good because:**

- The service provided a safe and clean environment that supported recovery. Clients, as part of their recovery programme, engaged in the daily running of the service and took responsibility for shopping, cooking and cleaning. They were involved in decisions on the running of the service and their own care and treatment.
- Staff levels and skill mix were planned, staff numbers changed to reflect the number of clients using the service. Any additional staff shortages were responded to using a dedicated bank staff cohort. There were daily flash meetings, effective risk management and multidisciplinary team meetings held to ensure staff could manage risks to clients.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients and families and carers in care decisions. Clients were supported to take responsibility for their own recovery and staff supported them in a non-judgemental way to achieve this.
- Clients had their needs fully assessed and had recovery orientated care plans that were personalised and holistic. Clients were supported to maintain abstinence. Clients were safeguarded against abuse and discrimination.
- There was an effective recovery programme which met clients' needs. There was a strong multi-disciplinary focus with clients encouraged to develop links to the recovery community for support post discharge. Discharged clients were able to attend the service to access support and the programme continually prepared clients for discharge and living back in the community.
- The service was well led, and the governance processes ensured that procedures relating to the work of the service ran smoothly. Incidents were recorded and investigated. There was evidence that learning from incidents took place and this was shared with staff to improve the service.

# Summary of findings

## Our judgements about each of the main services

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

# Summary of findings

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Good

# Turning Point Leigh Bank

**Services we looked at**
Residential substance misuse services;

# Summary of this inspection

## Background to Turning Point - Leigh Bank Rehabilitation

Turning Point Leigh Bank Rehabilitation was registered with CQC on 4 July 2017 to provide accommodation for persons who require treatment for substance misuse.

Turning Point Leigh Bank Rehabilitation provides rehabilitation and support services for people aged 18 to 65 who are recovering from the impact of substance and alcohol misuse. The service provides residential rehabilitation services.

Funding for placements is provided by commissioners throughout the country and as a result some clients do not live locally.

The service has 16 beds, it has three ground floor rooms which are accessible for people with mobility problems and accommodate both male and female clients. They also provide a service where clients can attend the service on a non-residential basis.

There is a registered manager in place with service last inspected in April 2016, however the service is now at a different location. On that occasion they were fully compliant with the regulations.

## 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 including the provider information return that the registered manager had submitted.

During the inspection visit, the inspection team:

- Visited the service and looked at the quality of the environment and observed how staff interacted with clients;
- spoke with 12 clients who were using the service;
- spoke with the registered manager and regional manager for the service;
- spoke with three other staff members; including recovery co-ordinators, and a volunteer;
- attended and observed a flash meeting (these are daily team meetings);
- looked at five care and treatment records of clients, and all medicine charts;
- 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

We spoke with 12 clients during the inspection. All clients felt that the environment was safe and clean.

All clients spoke highly of the service and felt that the programme was helping them in their recovery. All clients felt involved in their treatment and able to raise concerns.

Many expressed a desire to continue their recovery by becoming peer mentors.

# 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 service provided an environment which was clean, safe and well-maintained. Clients were encouraged to build social skills by engaging in daily living tasks.
- The service had enough staff to ensure client safety and engagement. Staff were up to date with mandatory training.
- Each client had an up to date risk assessment and risks were managed appropriately, there were effective systems in place to manage clients' own medication.
- There were emergency medicines in stock at the service. Staff and clients had received training on how to administer emergency medicines.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

### Are services effective?

Good

We rated effective as good because:

- Clients had a comprehensive assessment completed when they entered the service. Care plans were personalised, recovery orientated and holistic.
- Staff provided a range of care and treatment interventions suitable for the patient group. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives and maintain abstinence.
- Managers made sure the service had staff with a range of skills needed to provide a high quality of care. They supported staff with supervision and opportunities to update and further develop their skills.
- The service had good links with community teams, primary care and other local services.

### Are services caring?

Good

We rated caring as good because:

# Summary of this inspection

- Staff treated clients with compassion and kindness. They respected clients' privacy and dignity and supported their individual needs. Staff involved patients and those close to them in decisions about their care and treatment. The provider included clients when they made changes to the service.
- Staff communicated well with clients, so they understood their care and treatment. They involved clients in care planning and when undertaking risk assessments and actively sought their feedback on the quality of care provided.

## Are services responsive?

Good

We rated responsive as good because:

- The service had clear criteria for admission which included being abstinent from drug and alcohol. The service worked closely with referring teams to ensure clients were prepared for the programme.
- Clients had access to resources in the community and were encouraged to build a supportive network ready for discharge. The provider encouraged clients to access community services such as Alcoholics Anonymous and Narcotics Anonymous.
- Clients were supported to maintain relationships with their families.
- There was a proactive approach to understand the needs of diverse groups of people and to deliver care in a way that met those needs and promoted equality. This included people who were vulnerable and/or had complex needs.

## Are services well-led?

Good

We rated well-led as good because:

- The manager had the skills, knowledge and experience to perform their role. They had a good understanding of the services they managed and were visible in the service and approachable for clients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- The service had an effective governance structure. Governance policies, procedures and protocols were regularly reviewed, improved and were all up to date. The management of risk, issues and staff performance was effective.
- Staff morale was good, and staff felt listened to and respected.

# Detailed findings from this inspection

## Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

## Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act which staff were aware of and could refer to.

Mental Capacity Act training was included in the mandatory training package. The completion for training was 100% within the service. Staff ensured clients consented to care and treatment and this was assessed, recorded and reviewed on time. This was seen in all care records we reviewed on inspection.

Clients were supported to make decisions where appropriate and staff knew how to access further support if they had concerns around capacity.

## Overview of ratings

Our ratings for this location are:

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

Good

# Residential substance misuse services

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

## Are residential substance misuse services safe?

Good

### Safe and clean environment

Leigh Bank was a large Victorian house which had 16 bedrooms over three floors. Twelve of the bedrooms were en-suite. There was disabled access to the building with three accessible bedrooms and toilet facilities on the ground floor. The building was well maintained. All areas were visibly clean and tidy. A cleaning rota was in place and clients cleaned the service daily and prepared all meals as part of the recovery programme.

While Leigh Bank provided accommodation 16 clients they also accepted non-residential clients. They could vary the number of non-residential clients against the number of residents but had a maximum of twenty clients at any time.

The service kept records of all general areas, including, cleaning, kitchen, toilets and other health and safety issues such as water borne bacteria testing. The service recorded daily environmental checks in all rooms. Ligature risks were mitigated against by risk assessment of clients before admission.

Staff adhered to infection control principles, Cleaning materials and equipment were stored separately from other equipment.

The service had an up to date health and safety and fire risk assessment in place. There was an up to date fire evacuation plan with fire warden information displayed throughout the building. There was evidence of weekly fire alarms testing, and full fire evacuation drills taking place.

There were safety certificates to cover the maintenance and operation of the building including a business management continuity plan.

The service had a well-equipped clinic room, which was clean, tidy and had all necessary equipment which was calibrated and in date. There was emergency medication such as naloxone available. Staff carried out temperature checks of the fridges used to store medication and these checks were audited. Records seen on inspection were completed and up to date.

Clients we spoke with on inspection told us they felt safe when attending the service.

### Safe staffing

The provider had determined the safe staffing levels, the service had five substantive staff. When the service had over 11 residents an additional two members were added to the staff team. These were already Turning Point staff who worked in another substance misuse service. There were always three members of staff on site Monday to Friday between 9.00 and 17.00 and at the weekend one member of staff worked the same hours. Any additional shift vacancies were covered by an additional cohort of bank staff the manager could call upon.

An on-call system was in place outside the core staff hours and clients were given contact numbers of who to contact out of hours if needed. We saw evidence during the

inspection of where the on-call system had been used effectively and staff had responded. Cover arrangements were in place for sickness, leave, and vacant posts to ensure client safety.

During the previous twelve months no members of staff had left the service and agency staff had been used to cover six shifts. All agency staff were made familiar with the service and were given an induction.

The service had a daily flash and debrief meeting. In the meetings staff discussed risk management, client assessment and solutions to cover gaps in service delivery. For example, looking at available capacity within the staff on duty to cover additional service demand.

Staff told us they were happy, felt supported and had been in post for several years.

Staff had received and were up to date with mandatory training. This included 100% compliance for fire and safety awareness, health and safety, first aid, basic life support, handling information, infection control, governance, mental capacity act, positive behavioural support, safeguarding adults and children.

**Assessing and managing risk to patients and staff**

We reviewed five clients' records. Staff completed a full risk assessment for each client

and updated it should the risk change or after an incident. The case management system automatically created prompts for the staff when completing assessments ensuring any risks were identified. Positive risk taking, and least restrictive options were encouraged.

Staff monitored clients or any deterioration in their physical or mental health. There were good links with the local drug and alcohol service, mental health services and GPs.

As part of the 12-week residential programme clients were given advice on harm reduction including reduced tolerance and reducing the risk of overdose. There was a clear process for staff to follow to reduce the risk of harm following an unexpected discharge.

Naloxone training was given to clients. Drug and alcohol testing protocols were in place. There was a daily breathalyser test and urine tests were conducted randomly or were intelligence led. Any client found to be using drugs and /or alcohol was supported individually.

Incidents of substance misuse were assessed in the best interests and safety of the client and the other residents. Where it was not possible for the person to stay then they were discharged and supported to access community services.

Visitors were welcome at the service and clients could have home leave which was assessed on an individual basis.

**Safeguarding**

Staff received training in safeguarding adults and children and the staff we spoke with were knowledgeable about recognising signs of abuse and knowing when and how to refer to social care services. Compliance for both safeguarding adults and safeguarding children training was at 100%. There was evidence in care records of staff working closely with other agencies to promote safety and good evidence of information sharing where appropriate.

Staff understood how to protect clients from harassment and discrimination including those with protected characteristics under the Equality Act 2010 such as gender, disability, race and religion. They worked in a way that was non-judgemental and showed respect for the people they supported.

The service had made no safeguarding reports in the previous year; however, we saw evidence in records that staff were aware of ongoing safeguarding issues that existed prior to admission.

**Staff access to essential information**

Staff had access to an electronic system for client records, which provided them with prompt access to care records that were correct and up to date.

Staff used the electronic records for current recording. Staff understood the systems and did not report an issue with this. Staff had the equipment required to access records as they needed to.

**Medicines management**

Staff had effective policies and procedures in place relating to medicine management. Staff had received training and followed best practice when storing medication. Clients before admission agreed that for the first two weeks the service would store their medication while they were assessed to determine whether they would be responsible for their own medication. Clients who were responsible for their own medications stored these in a locked safe in their

bedrooms. Any client who did not wish to be responsible could have their medication stored by the service and was supported by staff to access this. Processes were in place to record and monitor client's medications.

Clients were registered with a local general practitioner to ensured monitoring of physical health took place. The service offered blood borne virus testing and vaccinations for hepatitis through a local community substance misuse service. All staff and clients were trained in the use of naloxone, all clients were given naloxone pens. The early use of naloxone a non-addictive, life-saving drug, can reverse the effects of an opioid overdose.

**Track record on safety**

There had been no serious incidents in the 12 months prior to our inspection.

**Reporting incidents and learning from when things go wrong**

The service used an electronic recording system for incidents and staff knew how to use this and understood what they should be reporting. From April 2018 to April 2019 staff had reported 55 incidents. Incidents were investigated and discussed at local and national governance meetings within Turning Point so that themes could be identified, and actions taken. Managers shared the outcome of any investigation including patterns and themes with staff in team meetings.

Staff had a good knowledge and understanding of when and how to report an incident. Managers received training in reporting and investigating of incidents and root cause analysis investigation.

A duty of candour policy was in place which reflected the provider's duty to the regulation. The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to clients if there have been mistakes made in their care that have or could have potentially led to significant harm. Staff had access to the duty of candour policy, which was not part of the provider's mandatory training requirement. Staff we spoke with were aware of how to report incidents, including being open and honest with clients when things go wrong. Staff said they understood the provider had to investigate all incidents and apologise to clients if the provider was at fault.

## Are residential substance misuse services effective?

(for example, treatment is effective)

Good

**Assessment of needs and planning of care**

Staff completed a comprehensive assessment of each client before they came into the service. The assessment considered the client's substance misuse, physical health, mental health, social factors, criminal history, previous treatment episodes and family situation.

We reviewed five records and found each record had a completed assessment and recovery plan which had been regularly reviewed. Staff developed care plans that met the needs identified during assessment. Care plans were personalised, holistic and recovery-oriented and identified the persons key worker. Care plans were updated when necessary. Individual risk management plans were regularly reviewed. The recovery star was used to monitor progress.

Clients felt that staff had considered their needs during the assessment process and that this was regularly discussed in key work sessions and groupwork.

Systems were also in place to allocate staff who provided post discharge support. Staff worked closely with anyone identified as being at risk of leaving the service and supported anyone who left the service unplanned to access services back in their local area.

**Best practice in treatment and care**

Staff provided a range of care and treatment interventions which were evidence based. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. The programme had been adapted to a residential setting by the provider's clinical psychologist in consultation with clients, staff and stakeholders.

Staff provided group and key work sessions underpinned by recommended interventions including cognitive

behavioural therapy, motivational interviewing and solution-focused brief therapy. This was in line with the Department of Health's guidance that treatment for drug misuse should always involve a psychosocial component.

Staff supported clients to live healthier lives. For example, through participation in smoking cessation schemes, healthy eating advice, exercise and dealing with issues relating to substance misuse.

Outcomes were monitored through a process called Treatment Outcome Profile. This assessed more social outcomes in relation to physical health, social connectedness, and housing.

Staff participated in clinical audit which was managed by the providers risk and quality team. Staff collected information on client outcomes.

**Skilled staff to deliver care**

Staff were experienced, qualified and had the right skills and knowledge to meet the need of clients. There was a manager, a clerical support worker and recovery workers. Robust recruitment processes were in place and all staff had a current Disclosure and Barring Service check in place. Managers identified the learning needs of staff through supervision and annual appraisals. Staff received regular supervision. This took place every four to six weeks and was at 100% of staff. We reviewed two personnel files and saw that supervision notes were detailed and included actions which were followed up. Staff received an annual appraisal and currently 100% of staff had been appraised.

Specialist staff training was available, and staff told us they were taking additional courses self-development and leadership qualifications.

The service had no staff members undergoing staff performance management. However, poor staff performance would be addressed through supervision and if necessary using the formal process set out in Turning Point's policies and procedures. Managers had access to a policy and the Turning Point human resources team to support this if needed.

Recruitment of staff was in line with Turning Point's national policy. The service recruited volunteers who went through the same robust recruitment process as permanent members of staff. Volunteers received the same induction programme, completed the same mandatory training and had access to the same support available to all staff. The service did employ previous clients. The provider recruitment and selection policy outlined the process for identifying any additional risk assessments or support plans.

**Multi-disciplinary and inter-agency team work**

Clients came from various locations. However, staff had regular contact with client's care coordinators from their local substance misuse teams. The service worked closely with social services, mental health services and criminal justice services. There was a multi-disciplinary approach to each client's comprehensive assessment, which identified if the person was ready for the programme. Staff shared information about clients at effective handovers and shared information with other services involved with the client. There were effective working relationships with community drug and alcohol services and community mental health teams.

We observed daily flash meeting. Staff attended these meetings that lasted approximately 30 minutes each morning. The meetings discussed staff issues, the day's activities, incidents from the previous day, and any key concerns about clients. Staff spoke positively saying the introduction of the meetings had brought a focus and clarity for the objectives for that day.

There was strong relationship with local substance misuse services with clients having access to service provided by that service such as blood borne virus testing. Clients attended numerous sessions within the recovery community as well as having interventions delivered at service from external agencies. Clients told us that these links had made this service more effective is assisting their recovery.

The service discharged people after 12 weeks if the client and staff agreed that this was suitable. Clients could apply for funding to stay longer if this was identified as part of their care plan. Staff worked with supporting agencies in the community to ensure timely transfer of information.

**Good practice in applying the Mental Capacity Act**

The service had a policy on the Mental Capacity Act. Staff were aware of this and understood how the act would be used with their client group.

Mental Capacity Act training was included in the mandatory training package and 100% of staff had completed training on the Mental Capacity Act.

Good

# Residential substance misuse services

Staff assumed capacity and supported clients to make their own decisions. Clients who lacked capacity would not be suitable for the service. This was reviewed throughout their stay and related to specific decisions. Staff understood fluctuating capacity should clients become under the influence of substances or alcohol and had clear guidelines to follow.

## Are residential substance misuse services caring?

Good

### Kindness, privacy, dignity, respect, compassion and support

The 12 clients we spoke with said staff treated them with dignity and respect. They stated that staff showed them understanding and were kind to them. During our inspection we saw interactions between clients and staff. These were consistently positive, with staff always being polite and respectful.

Staff stated they could raise concerns about disrespectful, discriminatory or abusive behaviour towards clients and would be listened to by managers.

Staff spent time explaining things to clients and ensuring they had the information they needed to understand the treatment offered and remain safe and well. Clients told us they were always given options about their treatment and that all aspects of their care were explained. Clients said they could also access other support services such as other agencies supporting addictions to drugs, alcohol, gambling.

Staff displayed a range of information for clients around the service about other organisations and supported clients to access other support such as housing and benefits when needed.

Turning Point had clear policies on confidentiality and staff knew what these were and used them to protect the information about their clients. Information was shared with clients' consent or in circumstances when significant concerns about a client's safety had been raised.

This was explained to clients during their initial assessment and at other times during their support. We saw consent forms in all records.

### Involvement in care

Each client was appointed to a key worker. We saw evidence that the client was involved in the setting of relevant goals and in the regular reviewing of goals, progress and outcomes.

Staff communicated effectively with clients, and clients told us they understood their care and treatment. We saw examples of staff finding effective ways to communicate with clients with communication difficulties. For example, providing information in accessible format for clients with a visual disability, there was also access to an interpreter service.

The service empowered and supported access to advocacy and mutual aid in the community. Each client had a recovery plan and risk management plan in place that demonstrated their preferences, for recovery goals. Recovery plans demonstrated client involvement.

Clients feedback was gathered through a variety of mediums including surveys, meetings and discharge interviews. We saw evidence that clients' feedback had influenced service change, for example clients had complained that two supermarket shopping trips a week were insufficient to cater for all their needs, so the service had introduced a third trip into the weekly program.

Weekly house meetings took place and clients were expected to take responsibility for the running of the house during their stay. A rota was in place for household tasks and each person was responsible for a different one each week. The clients did their own shopping and meal preparation. New clients were supported by others on the programme.

Staff involved families when appropriate in a client's treatment and care. Clients were supported to maintain contact with families and in many cases to regain contact after relationships had broken down. Visits were encouraged with facilities for children to visit.

Clients were involved in deciding the day to day running of the premises, drawing up rotas and deciding who was responsible for what task. They were also responsible for enforcing house rules outside of staff hours. Clients told us they were all aware that they were trusted by the service to confirm to the rules and expected other clients to report

any occasions where these rules were broken, they told us there was no conflict between them. They gave feedback on the design of the 12-week programme through the weekly community meetings.

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

Good

**Access and discharge**

The service had clearly documented admission criterion. Clients needed to be abstinent

from drugs and alcohol. The service worked with care coordinators in their local teams to ensure that clients were prepared for the rehabilitation programme.

The service actively engaged with commissioners, social care and the voluntary sector to ensure that services delivered and met the needs to people using the service. The length of the programme was 12 weeks, but this could be extended if the client and service mutually agreed a longer stay was required. Discussion took place with commissioners and care coordinators if an extended period of stay was required.

Recovery and risk management plans reflected the diverse/ complex needs of clients. These included clear care pathways to other supporting services, for example social, housing or other mental health providers.

There were clear policies in place should a client discharge themselves unexpectedly. Staff supported those clients who left in an unplanned way to access services in their local community. This included drug and alcohol treatment services, housing services, mental health services and treatment for physical health.

There was post discharge support for clients. Clients were contacted within a week of being discharged and followed up again after three and six months. During the inspection we met former clients who were still accessing support at the service.

There was a waiting list to access the service. However, there was no emergency admission process as all clients had to be abstinent before admission.

**The facilities promote recovery, comfort, dignity and confidentiality**

The service had a range of rooms to support treatment and care. This included a communal living and kitchen area and private therapy rooms. Each client had their own bedroom, some had en-suite while others had access to a shared bathroom.

Staff delivered a range of groups for clients. These varied depending on the stage of a client's treatment and on the client's addiction. There was information available or displayed by posters relating to support groups, local services, health-based information, medications and current drug warnings.

All female clients were given bedrooms which had en-suite bathrooms. All female clients told us they felt safe and there were specialist policies in place to support clients who were pregnant.

**Patients' engagement with the wider community**

Staff encouraged clients to access positive and meaningful opportunities in the community with social, recreational and educational activities. Staff worked on this throughout their involvement with clients so that they could have the networks and meaningful activity to support their recovery in the longer term.

Staff encouraged clients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Staff promoted working with new communities, areas, agencies, vulnerable groups and stakeholders through attendance at meetings, conferences, and their dedicated wellbeing cloud, marketing material. The wellbeing cloud was an online virtual space which provided information to clients, families and agencies about recovery services.

**Meeting the needs of all people who use the service**

There was a proactive approach to understand the needs of diverse groups of people and to deliver care in a way that met those needs and promoted equality. This included people who were vulnerable and/or had complex needs.

The provider demonstrated an understanding of the potential issues facing vulnerable groups, (for example, lesbian gay bisexual transgender, black minority and ethnic

groups, older people, people experiencing domestic abuse and sex workers) and offered appropriate support. Staff had access to interpreters and signers for people with hearing loss.

### Listening to and learning from concerns and complaints

The provider had a clear complaints system and policies to ensure lessons were learnt. There were set time limits to respond to complaints and policies to ensure that lessons were taken forward at a local level. Complaints were collated by clinical governance meetings on a quarterly basis and provided recommendations to implement change.

Clients knew how to complain or raise concerns. All comments, complaints and feedback were recorded locally and monitored centrally. Managers ensured that all comments and complaints were dealt with and that clients received feedback. There had been six compliments and no formal complaints to the service in the previous 12 months.

Informal complaints from clients were dealt with as quickly as possible and those raised within the community meeting were recorded within those minutes.

## Are residential substance misuse services well-led?

Good

### Leadership

The service manager had the skills, knowledge and experience to perform their role. They demonstrated a good understanding of the client group and the impact supporting clients with complex issues could have on staff. They ensured staff delivered high quality care and this was demonstrated in the way we saw staff working with clients. The service was supported by the providers local and national organisational structures to ensure the safe running of the service.

Turning Point nationally had a clear definition of recovery and how clients can achieve this. The staff team understood how this was delivered through their service. They worked to the principle that with the right support anyone can recover.

The manager was visible and approachable for clients and staff. On inspection we saw them speaking to clients on first name terms. Staff told us on inspection that regional leaders were on site every week and were approachable and respectful.

### Vision and strategy

The provider had a clear vision and set of values that had been developed in consultation with clients and staff. Staff understood the providers vision and values and how they applied to the work of the service. The provider's senior leadership team communicated the vision and values to staff and these were visible at the service. Staff had the opportunity to contribute to discussions about the strategy for their service. Staff contributed to improvement for the service through team meetings and service delivery projects.

All staff had a job description including volunteers in the service.

### Culture

Staff felt respected and valued. Staff we spoke with felt supported by the service and manager in their roles and felt they worked within a very caring and supportive staff group.

Staff appraisals included discussions about professional development and we saw in the personnel files that these were detailed with actions to be undertaken by managers and the staff member. Staff were supported for their own physical and emotional health needs. Staffing issues with the service had been dealt with appropriately.

Staff felt able to raise concerns and understood the whistleblowing process. Managers dealt with poor staff performance.

Equality and diversity were promoted within the service. The service supported clients to access the LGBT community, places of worship and any faith-based organisations. Clients' needs were individually assessed, and support provided from staff to access services in the community.

### Governance

The service had an effective governance structure. Governance policies, procedures and protocols were regularly reviewed and improved and were all up to date. There were effective ways of monitoring the service and for

raising concerns. All staff received the appropriate training and regular supervision. Staff had a good understanding of safeguarding and the Mental Capacity Act, they used these to ensure clients received safe care.

There was a clear framework of what had to be discussed at team and management level team meetings that ensured essential information such as learning from incidents and performance indicators were shared and discussed.

Turning Point provided data management support at a corporate level to monitor and report on performance. We saw that the manager had access to data about the service's performance.

Staff took part in local clinical audits. The audits were enough to provide assurance and staff acted on the results when needed.

Data and notifications were given to external bodies and internal departments as required including notifications to the CQC. For example, Turning Point provided commissioners with their internal reporting process document and any incidents were notified to commissioners and discussed in monthly contract meetings. They also used treatment outcome profile data as a national comparator.

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

**Management of risk, issues and performance**

There was a clear quality assurance and performance framework in place. This included a local risk plan and actions relating to this and how they would be achieved. Staff could raise concerns around risk for the service with managers who could escalate these to Turning Points national risk register through governance meetings.

The service had plans for emergencies such as adverse weather. They were clear about how cover would be provided and gave information to clients by phone and through the website about how they could access support if they needed to.

Performance information was submitted to Public Health England and the provider used activity reports alongside information from their own systems to monitor the performance of the service.

**Information management**

Staff had access to the current information and equipment required to complete their roles and to provide client care. They used electronic systems to maintain client records. Staff felt confident in using the systems and could demonstrate an awareness of information governance.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care.

Information was in an accessible format, and was prompt, accurate and identified areas for improvement.

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

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

The service ensured confidentiality agreements were explained including in relation to sharing of information and data.

**Engagement**

Staff, clients and carers had access to up to date information about the work of the service though the internet, notice boards, leaflets and social media platforms.

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Client, staff and stakeholder consultations were completed as well as joint events held when the service model was changed.

Clients and staff held weekly community meetings at which they could give feedback about the service.

Managers engaged with external organisations such as the commissioners for the service. They sat on local safeguarding committees and attended other local charities board meetings. They also had effective partnerships with the police, probation service, domestic violence groups and close links with the area substance misuse service.

**Learning, continuous improvement and innovation**

Good

# Residential substance misuse services

Staff were encouraged to be creative and innovative to ensure up to date evidence-based practice was implemented and imbedded. Mindfulness had been introduced into the 12-week programme.

The service continually assessed quality and sustainability and the impact of changes to the budget they received from commissioners. They adapted the service they offered while maintaining the quality of the service using group work and volunteers.

The manager had developed the service through support from other agencies. There were three counsellors who as part of their professional training delivered different therapies to support clients. A local domestic violence charity also delivered one to one support for victims of domestic violence in a structure program.

The service and staff objectives reflected the organisations values and objectives focussed on improvement and learning.