Littledale Hall Therapeutic Community

Quality Report

Littledale Hall,
Lancaster,
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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?	Requires improvement

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 Littledale Hall Therapeutic Community as good overall because:

- The findings of this inspection mean the service is being removed from special measures. The service had taken actions to address concerns identified at our previous inspection. There was clear evidence that the service had improved.
- The service provided a safe rehabilitation service for individuals with substance misuse problems. The environment was safe, clean and supported recovery. The service had enough staff. Staff assessed and managed risks associated with the client base and rehabilitation well.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet. The service had facilities and equipment to support the delivery of care. Staff managed privacy and dignity within shared dormitories appropriately. There was access to outside space.
- The service had taken steps to improve its governance. Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

However;

- Although the service had reviewed its policies and procedures it had not yet fully implemented them and staff had not yet completed all relevant training.
- A management plan in place for a client with diabetes did not provide details or instruction for staff to follow if blood sugar levels were outside of the normal range.

Summary of findings

Contents

Good

Littledale Hall Therapeutic Community

Services we looked at
Residential substance misuse services;

Summary of this inspection

Background to Littledale Hall Therapeutic Community

Littledale Hall Therapeutic Community is a 32-bed residential substance misuse service. It offers psychosocial rehabilitation services to individuals with substance misuse and addiction problems. The service offers treatment to men and women over the age of 18. The service does not offer detoxification programmes. All clients undergo detoxification or are free from illicit substances before admission.

The service is registered to provide accommodation of persons who require treatment for substance misuse. The service has a registered manager and a nominated individual.

Littledale Hall Therapeutic Community has been registered with the CQC since December 2010. It has been inspected five times. At our last inspection in March 2019 the service was rated inadequate and placed in special measures. The service was rated inadequate in the safe and well-led domains; requires improvement in the responsive domain and good in the effective and caring domain.

We issued two warning notices. We issued one warning notice under regulation 17 (good governance). We identified that the service had not acted on the findings of audits; had insufficient systems and process to assess security risks to clients and staff; did not maintain daily contemporaneous records for clients; had not identified or acted on environmental issues and had policies and procedures that were out of date or insufficient.

We issued a second warning notice under regulation 12 (safe care and treatment). We identified concerns in relation to medicines management processes and procedures including the completion of medicines reconciliation; administration and self-administration practices; record keeping and the appropriate monitoring of fridge temperatures.

We also issued two requirement notices under regulation 10 (privacy and dignity) and regulation 15 (premises and equipment).

Following the findings of this inspection and due to improvements made we are removing this service from special measures.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, one CQC inspection manager and a CQC medicines inspector.

Why we carried out this inspection

We inspected this service to follow up concerns identified in on our inspection of March 2019. The inspection was unannounced. This meant staff did not know we were coming, to enable us to observe routine activity.

Summary of this inspection

How we carried out this inspection

This was a focused inspection to follow up on previous regulatory breaches. During this inspection we asked three of our five key questions. We asked the following questions:

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

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

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for clients
- spoke with five clients who were using the service
- spoke with the nominated individual and the registered manager of the service
- spoke with six other staff members; including treatment practitioners, support workers, volunteers and the quality manager
- spoke with a commissioner
- looked at three care and treatment records of clients
- looked at nine medication charts
- carried out a specific check of medication management
- reviewed eight staff records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five clients who were using the service. Feedback we received was positive. Clients considered staff to be approachable, caring and supportive. Clients were positive about the treatment they were receiving and reported that they had been involved decisions about their care. Clients reported they had given feedback on the service and felt that they had been listened too.

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 provider had taken steps to address concerns identified in our previous inspection.
- The client environment was safe, clean, well equipped and well furnished.
- Staff completed regular checks of equipment and the environment. Appropriate maintenance records were in place.
- The service had enough staff, who knew the clients and received basic training in substance misuse and rehabilitation to keep them safe from avoidable harm.
- Staff screened clients before admission and only admitted them for rehabilitation if it was safe to do so.
- 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.
- Staff had easy access to clinical information and maintained good quality clinical records.
- Staff recognised incidents and reported them appropriately. Managers reviewed incidents and shared lessons learned with staff. When things went wrong, staff apologised and gave clients honest information and suitable support.

However:

- A management plan in place for a client with diabetes did not provide details or instruction for staff to follow if blood sugar levels were outside of the normal range.
- Not all staff had completed the identified medicines management training.
- The medicines fridge was not always locked.

Are services effective?

Good

The effective domain was rated as good following our inspection in March 2019. As a result, we did not inspect the effective domain during this inspection. The rating remained unchanged from our inspection in March 2019.

Are services caring?

Good

The caring domain was rated as good following our inspection in March 2019. As a result, we did not inspect the effective domain during this inspection. The rating remained unchanged from our inspection in March 2019.

Summary of this inspection

Are services responsive?

Good

We rated responsive as GOOD because:

- The provider had taken steps to address concerns identified in our previous inspection
- The service was easy to access. Staff planned and managed discharge well. The service had admissions criteria in place and these were adhered too.
- There were facilities to promote recovery. Staff managed privacy and dignity within shared dormitories appropriately. There was access to outside space.
- The service had good links with the local community and clients were supported to access community support and activities.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The service had not fully embedded its recently introduced policies, procedures and operational practices.

However:

- The service had taken steps to address concerns identified at our last inspection. Medicines management had been improved and changes to the environment had been made.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work. They felt able to raise concerns without fear of retribution.
- Managers had the skills, knowledge and experience to perform their role. Managers had access to leadership and management training.

Detailed findings from this inspection

Mental Health Act responsibilities

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Residential substance misuse services

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

Are residential substance misuse services safe?

Good

Safe and clean environment

The building was clean, well maintained and appropriately furnished. Littledale Hall Therapeutic Community was located within a two-storey building. As part of their treatment contract clients took responsibility for cleaning the building. Clients were allocated tasks through a cleaning rota. Completed rotas showed that the building was cleaned daily.

Staff completed daily, weekly, monthly and annual environmental checks. Appropriate maintenance checks were in place including for gas safety and legionnaires. There was an up to date fire risk assessment. Fire detection, prevention and fighting equipment had been checked regularly. Fire evacuation drills had been completed.

The ligature risk assessment had been reviewed and ligature cutters were available to staff. This had improved since our last inspection. Staff were aware of ligature points and how to access and use the ligature cutters.

Staff and clients felt safe within the service, this had improved from the last inspection. Clients had a secure sleeping space. The bedroom utilised by the night shift staff had a lock on it.

At our last inspection we identified that the décor in some bedrooms was in a poor state. At this inspection we found that a programme of redecoration had been implemented. Décor in the building had improved.

Staff adhered to infection control principles including hand washing and the disposal of clinical waste.

Safe staffing

Staffing levels were sufficient to meet the needs of clients. Clients had regular one-to-one time with staff. Planned activities and sessions had not been cancelled due to staff shortages. Clients could seek support from staff at any time. There were cover arrangements in place for sickness and leave. There were 12 members of staff. This included the registered manager, five treatment practitioners, two support workers, an admissions co-ordinator and an aftercare worker. In addition, the service was utilising a bank treatment worker. The staff member had previously worked full time at the service. The service had a vacancy for an administrator which was being recruited too. The service also employed an external quality manager.

Staff completed a programme of mandatory training. At the time of our inspection compliance with mandatory training in 2019 was 90.5%. Staff were booked on training for 2020. Compliance with mandatory training was monitored through a training matrix which was reviewed regularly by service management.

Assessing and managing risk to patients and staff

Staff assessed and responded to client risk. We reviewed three care records. All records contained a risk assessment

and associated risk management plans. These were reviewed regularly. Client risks were shared in handovers between shifts. Client records contained plans for an unexpected exit from treatment.

Staff monitored clients for any deterioration in their physical or mental health. Clients were registered with a local GP during their admission. The GP completed an initial physical health check within a week of admission. Clients had access to any required physical health tests or interventions through the GP. However, we found in one record that a physical health check had not yet taken place although physical health had been discussed during the client's admission.

At our last inspection we identified concerns over arrangements for night staff lone working. At this inspection we found that actions had been taken to address this. There was access to a phone in the staff bedroom and a lock had been placed on the bedroom door. An additional shift had been added from 6:00pm to 9:00pm to support the night worker. A staff member now lived on site and could provide immediate support if required.

The service had taken action to address concerns over blanket restrictions identified at our last inspection. Clients had access to their bank cards during the first stages of treatment. The search policy had been changed and clients were no longer automatically searched if they had left the premises. Clients had access to their mobile phone when they left the premises but had limited access to them within the premises. These rules and expectations were included in client information prior to admission.

Safeguarding

All staff had completed safeguarding training. Staff knew how to protect clients from abuse and the service worked well with other agencies to do so. Staff we spoke with displayed a sound knowledge of safeguarding principles and procedures. They were aware of different types of abuse and how to raise a concern. There was a safeguarding policy in place to support staff in managing and reporting safeguarding concerns. There were positive relationships with local safeguarding bodies.

Staff access to essential information

All information needed to deliver client care was available to relevant staff, including bank staff when they needed it and was in an accessible form. Staff maintained paper care and treatment records. These were secured in locked cabinets.

At our last inspection we identified a concern around the security of clients' therapeutic work completed in group sessions. Each client had their own folder, but these were stored in an open bookcase on a communal corridor. At this inspection we found that client folders had been moved and were now more secure.

Medicines management

At our last inspection we found that the service did not have systems in place to ensure the safe handling, storage and administration of medicines. At this inspection we found that the service had taken steps to address these concerns. A process to support medicines reconciliation was in place. The medicines policy had been updated to provide appropriate guidance and risk assessments for clients self-storing and administering medication. However, at the time of our inspection no clients were self-storing and administering medication.

Regular medicines audits had been completed. Issues identified had been discussed with individual workers and in staff meetings. Medicines were securely stored. The service had facilities to store controlled drugs. Medicine fridge temperatures were being monitored and any anomalies responded too. However, we found that the medicines fridge was not always kept locked.

Since our previous inspection the medicines policy had been reviewed. Staff involved in the handling of medicines had been enrolled onto a medicines training course. However, not all staff had completed the training at the time of our inspection. Staff had completed level one training. There were eight staff identified as requiring level two training. Staff including a new member of staff were booked onto the relevant units from starting from December 2019.

Staff regularly reviewed the effects of medication on clients' physical health and in line with guidance. Clients were registered with a local GP during their admission. However, we identified one client with diabetes. The client had a risk assessment and plan in place to ensure that they checked

their bloods as required. However, the risk management plan did not provide any information or guidance to staff on how to respond if blood sugar levels were outside of the normal range.

We reviewed nine medicines administration records. These were completed appropriately and signed. However, we saw one example, where an antibiotic was not taken as frequently as prescribed. We raised this with the manager, who took immediate action to seek advice.

Track record on safety

The service had not reported any serious incidents since our last inspection.

Reporting incidents and learning from when things go wrong

The service had systems in place to record and learn from when things went wrong. Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. Incidents were reported on paper forms. Incidents were reviewed by the service manager. Staff received feedback following incidents and identified learning was shared via email and at team meetings.

Staff understood their responsibilities under duty of candour. 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.

Are residential substance misuse services effective?

(for example, treatment is effective)

Good

The effective domain was rated as good following our inspection in March 2019. As a result, we did not inspect the effective domain during this inspection. The rating remained unchanged from our inspection in March 2019.

Are residential substance misuse services caring?

Good

The caring domain was rated as good following our inspection in March 2019. As a result, we did not inspect the caring domain during this inspection. The rating remained unchanged from our inspection in March 2019.

Are residential substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

The service had documented eligibility criteria and a clear referral and admissions process. The service employed an admissions co-ordinator to oversee the process. Referrals were accepted from both private and statutory sources. All referrals were assessed prior to admission to ensure their suitability for the service. Where clients had been referred from statutory community services staff worked with those services to plan the clients' admission and gather information to inform the assessment process.

Staff proactively planned discharge. This began from the point of referral. Staff worked with clients to identify services and resources within their home community that could help support their discharge and recovery. Care records included discharge plans.

Staff supported clients during referrals and transfers between services. For example, clients were supported to attend hospital appointments.

The service worked to remove barriers to engagement for vulnerable and hard to reach groups. These included sex workers, the homeless and clients with complex needs. Staff had positive links with a local lesbian, gay, bisexual and transgender support group. The service had previously worked with transgender clients.

The facilities promote recovery, comfort, dignity and confidentiality

The service had taken steps to ensure the privacy and dignity of clients sleeping in shared dormitory areas. The

service had purchased privacy screens that clients could request if they wished too. Clients were made aware of the shared sleeping arrangements prior to admission and could chose an alternative service if they were not happy with the arrangement. Clients we spoke with did not raise any concerns over the shared sleeping facilities. The service had purchased cork noticeboards to allow clients to personalise their sleeping area, for example with posters and photographs. Clients did not have secure storage facilities within their bedrooms but could store valuable items with staff in the main office.

The service had taken steps to improve the accessible bedroom and bathroom. The bedroom had been reduced to two beds. In addition, the service had changed its eligibility criteria to allow clients with limited mobility but to exclude wheelchair users. This reflected the suitability of the environment. Information had been shared with commissioning agencies and altered on the services website and promotional material.

At our last inspection we identified that access to the family visiting room was down a steep set of stairs with no handrail. At this inspection we were shown alternative access to the visiting room. Although this included stairs they were not steep and a handrail was fitted.

Patients' engagement with the wider community

Staff supported clients to maintain contact with their families and carers. Visits with family members were encouraged and facilitated. Staff encouraged clients to develop and maintain relationships with people that mattered to them, both within the service and the wider community.

Staff promoted access to the local community and activities. There was a mini-bus available to support this. Clients accessed the local community to use recreational facilities such as the gym and to access shops and mutual aid groups. Where appropriate, staff ensured that clients had access to education and work opportunities. Clients were supported to attend a local college which provided courses on maths, English and information technology.

Meeting the needs of all people who use the service

The service was not able to accept clients in a wheelchair but were able to make adjustments for clients with limited mobility. Mobility concerns were identified during the referral process. Whereappropriate adjustments could not be made, orif appropriate facilities were already in usethe client was directed to an alternative service. There was an assisted bedroom with access to a shower and appropriate bathing facilities.

Communication needs were identified during the referral process and discussed with the client and where applicable the referring agency. The service had supported a client with partial sight by using online tools. Staff could access translation services, which included face to face, telephone and document translation through care coordinators and referral agencies.

Clients had a choice of food to meet their dietary, cultural or religious needs. Dietary requirements were identified during assessment and the service procured relevant produce such as halal meat or gluten free meals. Staff supported clients to access local places of worship.

The service had a range of leaflets and information boards on display within the unit. These

included information on treatment, recovery, local services, advocacy and mental and physical

health advice.

Listening to and learning from concerns and complaints.

The service had a complaints policy and process. Clients we spoke with told us they would be comfortable raising a complaint and felt that it would be managed appropriately. Clients we spoke with had not raised formal complaints but had discussed low level concerns informally with staff. They told us that they had been happy with the response that was provided.

Staff we spoke with were aware of the complaints process and were able to describe how it worked. Learning from complaints was discussed in team meetings and supervision sessions.

Are residential substance misuse services well-led?

Requires improvement

Leadership

The leadership team displayed a good understanding of the service, the clients and the challenges they faced. They were able to discuss changes that had been put in place since our last inspection and future. They had the skills, knowledge and experience to perform their roles.

The leadership structure had changed since our last inspection. The previous nominated individual had left the service. The registered manager was currently acting as nominated individual. A treatment practitioner was stepping into the registered manager role and acting as the deputy service manager. Both staff members had received leadership training.

Staff spoke positively about the service managers. They praised the managers response to our last inspection and described them as supportive and open. Managers were visible within the service and approachable for clients and staff.

Vision and strategy

Staff knew and understood the vision and values of the service. They were able to discuss these and how they influenced their work and service delivery. The vision and values were reflected in the delivery of care.

Staff had the opportunity to contribute to discussions about the service and service development. They were involved in making decisions around changes to the service. Staff we spoke with told us that managers were open to ideas and suggestions from both themselves and clients.

Culture

The service had a positive culture. Staff we spoke with told us they felt respected and valued. Staff described a difficult year and praised management for the support they had offered during that time. In addition to the nominated individual, four other staff had left in the previous 12 months. This had been due to voluntary redundancy, personal issues and disciplinary or grievance procedures. Staff told us that staffing had settled in the months prior to our inspection.

Staff we spoke with were clear about their roles and responsibilities. They were proud about the work they did and the level of care they provided. They described an open and honest culture and a collaborative team working ethos. Staff we spoke with understood the provider's whistleblowing policy and felt able to raise concerns without fear of retribution or victimisation.

Staff morale was positive. Staff worked well together and demonstrated positive team working. Staff appraisals and supervision sessions included discussions about professional development. Staff were able to access additional training and experience as part of their development.

Staff reported that the provider promoted equality and diversity in its day to day work. Staff completed diversity training as part of their mandatory training package. Compliance with training was 77% (ten out of 13 staff).

Governance

The service had systems in place to identify and mitigate risks to clients and staff including staff safety when lone working. This was an improvement from our last inspection. We found that medicines management had been improved. The service had addressed environmental concerns. A ligature risk assessment and ligature cutters were in place. Changes had been made to support staff working nights. Staff were now maintaining contemporaneous daily client records.

We found that not all policies and procedures had been implemented and embedded into the service. At our last inspection we identified that policies and procedures were inappropriate or out of date. At this inspection we found that the service had reviewed its policies and procedures. Polices were now current and contextual to the service and client group.

Staff were required to sign to confirm they had read each policy. At the time of our inspection only five staff members had done so. Elements of new procedures had not yet been completed. For example, although the medicine policy had been reviewed not all staff had completed the identified training. Not all policies had been rolled out. For example, the risk and issue management policy was due to be ratified and rolled out to staff at the start of 2020. Some policies, for example the lone worker policy referred to training that was due to be delivered in 2020. This meant that new policies, procedures and operational practices were not yet fully embedded within the service. We discussed this with the service manager who confirmed that the service was developing an implementation plan.

Good

Residential substance misuse services

All policies and procedures were due to be implemented by the end of March 2020. This was outside of the timescale the service identified in their action plan following our last inspection. The action plan had a completion date of July 2019.

The service manager and relevant staff completed audits of care records, medicines management and the environment. The service employed an external quality manager on a part-time basis. The service was accredited with the Quality Management System ISO 9000-1. A service audit had been completed in June 2019 and was due to be completed again in February 2020. Work had been undertaken to develop quality performance indicators. Systems were in place to gather feedback from staff, clients, carers and commissioners.

Staff had access to regular team meetings and there was a clear framework of what was to be discussed. There was a monthly operations meeting where service management reviewed performance, incidents and feedback. Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of clients.

Management of risk, issues and performance

At our last inspection we identified that the service did not have systems in place to adequately identify and mitigate risks to clients and staff. At this inspection we found that the service had taken some steps to address this. Staff assessed risk in a variety of ways including client risk assessment, specific risk assessments such as the ligature risk assessment and regular monitoring of the environment and equipment. However, there was no over-arching risk register for the service. This was due to be introduced and rolled out as part of implementing the new risk and issue management policy at the start of 2020.

Service management held a monthly operations meeting where performance was discussed. This included reviews of audits, incidents and staff and client feedback. The service had plans for emergencies and business continuity including in the event of fire or flooding.

Information management

Staff had access to the information and equipment required to carry out their roles and deliver treatment. Information needed to deliver care was in an accessible format and stored securely.

Staff used paper care records. These were stored securely and were available to staff when they needed them. Governance records, polices and supporting documents were stored electronically. Access to this was secure and password protected. Key policies and guidance were available in printed form. Staff felt confident using the systems in place.

Service managers had access to information to support the management of the service. This included information on performance, staffing and client feedback.

Notifications and data were submitted to external bodies as required, including the CQC.

Engagement

Staff, clients and carers had access to up to date information about the work of the service through the internet, team meetings, notice boardsand social media platforms. Managers maintained good contact with stakeholders and family and put on regular engagement events.

Clients and carers had opportunities to give feedback on the service. There was space for clients to give feedback daily which was encouraged as part of their programme. Clients and carers also completed service evaluation forms. Service managers reviewed and acted upon client and carer feedback.

Service managers engaged with external organisations such as local commissioners and the CQC. There were effective partnerships with local safeguarding bodies, support services and the local recovery network.

Learning, continuous improvement and innovation

The service was committed to improving care and treatment from learning when things went well

or went wrong. The service reviewed adverse incidents and completed audits. Actions were identified and completed. Staff we spoke with reported that managers were receptive to new ideas and encouraged improvement.

The service made efforts to gain feedback from staff, clients, families and partner agencies to improve the quality of treatment provided. Clients and family members completed evaluation surveys.

The service was accredited under the Quality Management System ISO 9000-1 scheme.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that policies and procedures are embedded in the service and that relevant implementation plans and training are delivered.

Action the provider SHOULD take to improve

- The provider should ensure that clients have comprehensive care plans in place for health concerns such as diabetes.
- The provider should ensure that all staff complete the required medication management training

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service had not fully implemented and embedded new policies and procedures This was a breach of regulation 17 (1)

This section is primarily information for the provider

Enforcement actions

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.