

Mount Carmel Hostel for Recovering Alcoholics Limited

Mount Carmel

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good	
Are services safe?	Requires Improvement	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

Overall summary

Mount Carmel provides residential rehabilitation for people with serious alcohol problems. It does not take people who require detoxification.

We rated it as good because:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of therapeutic treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audits such as record keeping and medicines record keeping, to evaluate the quality of care they provided.
- Clients told us they were highly satisfied with the way staff treated them. Staff displayed a great deal of passion and knowledge of their work and had a good understanding of the specific needs and characteristics of each client.
- The service had free after care for life. Clients we spoke to felt inspired when they met previous clients who had been in the service.
- The premises were safe and clean. The number of clients in the service was not too high to prevent staff from giving each client the time they needed. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff facilitated a range of activities and therapies every day. For example, choir, sound therapy, group hypnotherapy, equine assisted therapy, dramatherapy, auricular acupuncture, Indian head massage and reflexology.
- The registered manager had the skills, knowledge and experience to perform their role, had a good understanding of the service, and were visible in the service and approachable for clients and staff.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received appropriate training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- 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 was well led, and the governance processes ensured that its procedures ran smoothly.
- Clients we spoke to stated that they would recommend the service to others and felt the service provided a realistic routine in preparation for independent living. Clients enjoyed the variety of group sessions the service offered, and good meals prepared by the service chef.

However:

- A review of stock medicines showed that some medicines held on the premises were not within the expiry date and some medicines had been left out in an unlocked room. Staff did not always record whether clients had allergies on their medicine administration records or who had completed the record. Clients who were self-medicating did not have access to locked storage in their rooms where they could keep their medicines safely.
- Some staff we spoke with could not give examples of how the service met the particular needs of people with protected characteristics.
- Staff had access to first aid kits located on each floor of the building, that staff checked these on a monthly basis. However, we found that the dressings in all three kits were past their expiry date but these were discarded once we brought this to the attention of the staff.

Summary of findings

- Although staff gave examples of incidents and learning from these that was shared in handover meetings, the service did not document these discussions. There was a risk that not all staff would know about these and therefore implement them effectively.
- The provider did not have a clear framework of what had to be discussed at team meetings to ensure essential information was shared amongst the staff. The records of staff meetings lacked detail. Some staff reported that the service did not have regular team meetings.

Summary of findings

Our judgements about each of the main services

Service

**Residential
substance
misuse
services**

Rating

Good



Summary of each main service

Mount Carmel provides residential rehabilitation for people with serious alcohol problems. It does not take people who require detoxification.

Summary of findings

Contents

Summary of this inspection

Background to Mount Carmel

Page

6

Information about Mount Carmel

6

Our findings from this inspection

Overview of ratings

9

Our findings by main service

10

Summary of this inspection

Background to Mount Carmel

Mount Carmel provides residential rehabilitation for people with serious alcohol problems. The primary model of treatment offered at the service is the 12-step programme. The average length of stay is three to six months. The service offers day programmes that is supplemented by therapy groups, peer support and individual counselling sessions. Clients using the service must have completed a detox before admission as the service did not provide detox. The service helps people maintain abstinence and start their recovery journey. At the time of the inspection, there were 16 clients were self-funding or funded by their local authority.

The service is registered to provide the following regulated activity: Accommodation for persons who require treatment for substance misuse.

There was a registered manager in post at the time of the inspection.

Mount Carmel has been registered under the Health and Social Care Act 2008 since 7 January 2011. There have been five inspections carried out at Mount Carmel since registration. The last inspection was in 16 January 2017 which was focused inspection to follow-up on concerns raised from a comprehensive inspection in August 2016. At this inspection we found that clients who were self medicating did not have anywhere to lock their medicines securely in their bedrooms. We found that this was still an issue at our most recent inspection although the service had put locks on bedroom doors.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to clients, staff and our inspection team. This meant that we limited the amount of time we spent in the service to prevent cross infection. Whilst on site we wore the appropriate personal protective equipment and followed local infection control procedures. We carried out staff interviews via video, as well as analysis of evidence and documents. Our final video call interview was completed on 11 January 2022.

What people who use the service say

Clients we spoke to stated that they would recommend the service to others. They valued being involved in the review of their care and felt staff understood their needs well. Clients said that Mount Carmel felt like home and provided a realistic routine in preparation for independent living. Clients enjoyed the variety of group sessions the service offered, and good meals prepared by the service chef. Clients felt they could approach any staff member to talk to whenever they needed.

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?

Summary of this inspection

- Is it responsive to people's needs?

- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for clients

- spoke with three clients who were using the service

- spoke with the service manager and deputy service manager

- spoke with 10 staff members, including counsellors, registered nurse, social worker and housekeeping staff

- looked at four care and treatment records of clients

- observed a staff handover

- carried out a specific check of the medication management and looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Outstanding practice

We found the following outstanding practice:

The service offered free after care for life. This meant that former clients could return to the service to access counselling sessions, an aftercare group twice a month, access to therapeutic group activities, evening meals and use of laundry facilities and offer support to other clients in the form of testimonials. At the time of the inspection a former client had been accessing the free after care for over 20 years.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that all medicines are stored safely and securely and are, within expiry date. All medicine administration records must record whether or not a client has an allergy and include the names of staff completing them. Regulation 12(2)(e)
- The provider must ensure that clients are able to store their medicines securely in their bedrooms. Regulation 12(2)(e)

Action the service SHOULD take to improve:

- The provider should maintain cleaning records for the clinic area and all communal areas of the service.
- The provider should ensure all first aid equipment is in date.
- The provider should ensure that staff meetings are recorded to enable all staff to read what was discussed and follow a consistent format.
- The provider should ensure that actions identified in response to incidents are recorded and shared with all staff.

Our findings

Overview of ratings

Our ratings for this location are:

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

Residential substance misuse services

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

Are Residential substance misuse services safe?

Requires Improvement 

We rated safe as requires improvement.

Safe and clean environment

The premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Staff made sure equipment was well maintained, clean and in working order.

The service did not keep up-to-date cleaning records for most areas on the premises that were cleaned regularly, records were limited to bathrooms only. However, at the time of the inspection the service was visibly clean.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. Staff completed regular environmental risk assessments including a ligature risk assessment. Staff had completed a fire risk assessment. The risk assessment identified key risks. The service completed monthly fire inspections that looked at fire extinguishers and fire doors. The fire risk assessment was up-to-date and due for review in May 2022. Fire testing was carried out on a weekly basis and the last annual fire drill had been carried out on 21 July 2021.

The service did not have call bells and staff did not carry personal alarms. The service completed a risk assessment of client prior admission to the service and for clients currently in the service to review if they were suitable for the service. Some of the admission risk exclusion criteria included risk history of violence and was reviewed during admission. The service manager reported they had additional support for clients such as sessions on emotions and anger management. There had been no incidents of violence since the service opened.

Staff followed infection control guidelines, including handwashing guidance and wore appropriate personal protective equipment. Staff we spoke with knew the COVID-19 procedures for the service. Staff also discussed COVID-19 procedures with clients at weekly house meetings. There were arrangements in place for staff to undertake COVID-19 tests. The service had a system and guidance on recording the results or responding to a positive test result. Staff adhered to regular testing.

Residential substance misuse services

Staff had access to first aid kits located on each floor of the building, that staff checked on a monthly basis. We checked three first aid kits and noted that the dressings in all three kits were past their expiry date but these were discarded once we brought this to the attention of the staff. We discussed this with staff who promptly removed all the expired dressings.

The service had an automated external defibrillator for use in the event of an emergency. As the service was not staffed at night, clients were advised to use a phone in the service that allowed calls to on call staff, if they needed assistance. In the event of a medical emergency clients were advised to dial 999.

Safe staffing

The service had enough staff, who knew the clients and received appropriate training. The service did not have any staff vacancies at the time of the inspection and had very low turnover rates.

The service ensured robust recruitment processes were followed. The provider had carried out the appropriate checks to ensure the fitness of staff to work with clients including interviews, and criminal records disclosure for all staff, including volunteers.

Managers made arrangements to cover staff sickness and absence. Managers supported staff who needed time off for ill health. Sickness levels were low.

The service operated a shift pattern of 8.00am to 7.30pm during the week and between 10.00am and 5.00pm at weekends. A member of staff was on call outside these hours, with a senior manager as additional support. The service had a risk assessment for out of hours that included reviewing clients risk history, mental health, physical health and any serious incidents. These were completed when there was a new admission to the house, or an incident occurred. Clients told us that when they used the out of hours on-call service staff attended promptly and responded to queries without delay. The service had a policy regarding on call duty that included lone working protocols.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The overall compliance for mandatory and statutory training courses was 95%. Mandatory training included subjects such as, first aid, health and safety and safeguarding. The mandatory training programme was comprehensive and met the needs of clients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Staff made clients aware of harm minimisation and the risks of continued substance misuse. Safety planning was an integral part of recovery plans.

During the inspection, we reviewed four clients risk assessments and risk management plans. Staff had completed risk assessments on admission for each client and reviewed these regularly. Two of the four risk assessments had a risk

Residential substance misuse services

management plan in place but two did not. However, staff we spoke with were aware of specific risk issues affecting each client. Staff had completed care plans that addressed most of the individual risks identified. Risk assessments included areas of potential risk, such as stress factors or relapse. Staff screened for common risks associated with substance misuse and risks concerning family and children.

All clients were registered at one GP local surgery on admission. Staff supported clients to have regular physical reviews and assessments of their physical health completed at the GP surgery.

Staff recognised when to develop and use crisis plans and advanced decisions according to client need. This included being prepared for risks around early or unexpected exit from the service with a plan that clients and staff could refer to.

Clients were made aware of the risks of continued substance misuse and harm minimisation safety planning was an integral part of care plans. There was evidence in client records of staff having regular conversations about the impact of alcohol use when risk assessments were reviewed.

Staff followed clear personal safety protocols, including for lone working. The service had a lone working policy for out hours that staff could access.

Safeguarding

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 we spoke to were aware of how to identify adults and children at risk of suffering harm and how to refer on as necessary to the local authority safeguarding team. Staff liaised with clients' social workers as required. The service had a safeguarding lead, who was the deputy manager, this meant that staff had a person they could go to for advice and guidance if they had a concern about a client's safety.

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff access to essential information

Staff kept detailed records of clients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service had made safeguarding referrals. Outcomes from safeguarding were shared with staff in handovers meetings.

Client notes were comprehensive, and all staff could access them easily. Staff used a paper records system and the records reflected that entries were made in timely fashion.

Medicines management

The service did not always store medicines safely, keep records up to date, record client allergies or monitor expiry dates of medicines.

Residential substance misuse services

We reviewed eight medicine administration records for completeness, legibility and inclusion of relevant client details, including allergies. We found that three medicine administration records for three clients did not state whether the client did or did not have any allergies and one medicine administration record did not have the name of the staff member completing the chart.

The provider stocked emergency medicines. However, review of stock medicines showed that one of two emergency medicines held on the premises had expired. We also found expired insulin stored in the clinic fridge. We discussed this with the provider who disposed of items promptly and in accordance with policy. A pharmacist carried out an audit every six months. The service quality assurance process did not include checking the expiry dates of medicines.

During the inspection we found a bag of medicine that had been left on a table in an unlocked clinic room that had not been stored safely. Staff we spoke to during the inspection promptly locked away the medicine.

The service clinic room was found to be dusty during the inspection. Staff did not keep a cleaning schedule for the clinic room.

Staff completed risk assessments for clients in respect of self-administering their medicines. At the time of the inspection most clients were self-administering medicines. Staff kept a log of medicines that clients had with them, and dates medicine was returned. Clients who self-administered medicines stored them in their rooms in dosette boxes. All client rooms had locks on their doors. During the inspection we looked at four clients' rooms and found that the rooms had been locked. However, the rooms did not have locked drawers or cupboards in their rooms for clients to keep medicines safely. The service manager stated that the service did not want places where clients could store illicit substances. However, clients could not store prescribed medicines safely in their bedrooms, allowing other clients and visitors potential access to medicines not prescribed for them.

Track record on safety

The service had a good track record on safety. Between 1 January 2021 and 1 January 2022, the service had reported no serious incidents.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave clients honest information and suitable support.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations (where appropriate).

Staff we spoke to give examples of incidents and how learning was shared in handover meetings. For example, staff response to threats of violence from people not using the service by reporting it to the appropriate authorities. However, the service did not document these discussions. Staff expressed concern that even though action plans were discussed there was a risk them not being carried out if they were not documented. Staff did not have a way of reviewing outcomes of the action plans.

Residential substance misuse services

Are Residential substance misuse services effective?

Good 

We rated effective as good.

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on accessing the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected clients' assessed needs. Two of the four care plans were personalised, holistic and recovery-oriented and two care plans had been recently reviewed with clients but lacked detail.

We reviewed care records for four clients and found their physical and mental health and been fully assessed and recorded on the first day of their admission.

Staff developed care plans with clients that addressed the needs identified in the assessment. The care plans were reviewed on a weekly basis with clients. Care plans were detailed, personalised, holistic, recovery oriented, recognised clients' strengths and views and described measurable goals. Paper copies of care plans were given to clients. Two of four care plans had individual and up to date comprehensive risk plans that were linked to up to date risk assessments.

Clients we spoke to knew who their allocated counsellor was. Each client had an assigned a counsellor, the name of their counsellor was recorded on the client record system.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.

The primary model of treatment offered at the service was the 12-step programme. This programme was supplemented by therapy groups, peer support and individual counselling sessions.

Staff made sure clients had support for their physical health needs, either from their GP or community services. Physical health checks were managed by the GP surgery and staff supported clients to attend appointments for these.

Staff were familiar with guidance issued by the National Institute for Health and Care Excellence (NICE). Staff delivered care in line with best practice and national guidance (from relevant bodies such as NICE). For example, staff spoke of the principle of building a trusting relationship and work in a supportive, empathic and non-judgmental manner with clients.

Staff took part in clinical audits monitor its quality of service and outcomes for clients. This included audits on medicines, care plans and risk assessment and used results from audits to make improvements.

Residential substance misuse services

Staff discussed with clients the importance of living healthier lives. Staff assessed all clients for their weight and height, and whether they smoked. Clients could access nicotine replacement therapy (NRT) through the GP. Staff supported clients to live healthier lives by supporting them to take part in programmes in the community or giving advice. However, there were limits to attendance at external groups due to the COVID-19 pandemic.

Staff did not use recognised rating scales to assess and record outcomes for clients. However, staff reported using questionnaires, peer meetings, care plan reviews and alcoholic anonymous meetings to measure the progress of clients in the service.

The service monitored client programme completion rates. Between September 2021 and December 2021, completion rates were between 71% - 77%.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers supported staff through regular, constructive appraisals of their work. All staff had completed annual appraisals in the past 12 months. Appraisals were part of key performance indicators that were monitored in the service committee meetings. Staff had monthly clinical supervision of their work.

The service did not have a clear framework of what had to be discussed at team meetings to ensure essential information was shared amongst the staff. Some staff reported that the service did not have regular team meetings. The service kept a notebook with handwritten notes that staff told us was used to document team meeting minutes. We reviewed notes for meetings between July 2021 and December 2021. The team meeting notes were not comprehensive, there was no clear agenda, the notes had minimal information on some meetings and at times it was unclear what the discussion was about. For example, in October 2021 notes stated 'phours inconsistency' and 'calling tx clients'. Some staff we spoke with stated that information was shared mainly in handover meetings. However, handover attendance was limited to clinical staff only and other non-clinical staff did not have a place to contribute to team discussions.

Managers recruited, trained and supported volunteers to work with clients in the service.

Multidisciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff ensured multidisciplinary input into the comprehensive assessment of clients. For example, input from community mental health teams, GP, detoxification clinics and carers. Input from a client's social worker was also sought where appropriate.

Staff made sure they shared clear information about clients and any changes in their care, including during transfer of care. Staff shared information about clients at effective handover meetings, which took place when shifts changed over.

Residential substance misuse services

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions about their care for themselves. They understood the service's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Staff understood mental capacity and worked on the principle that clients had capacity, unless an assessment confirmed they did not. If there was any doubt about this it was discussed with the staff team and an assessment was arranged. All new admissions had a full capacity assessment completed by the referrer, if needed.

Are Residential substance misuse services caring?

Good 

We rated caring as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with compassion and kindness. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.

There was a strong person-centred culture. Client feedback about their care, treatment and support from staff was positive. They told us that staff were caring, respectful, supportive and discreet where needed. Staff gave clients help, emotional support and advice when they needed it. Staff we met talked about valuing people and respecting their rights to make decisions.

Clients felt that having some staff with personal experience of substance use added valuable, practical and realistic information about how to meet the needs of clients, which were in line with national guidance.

Staff directed clients to other services and supported them to access those services if they needed help.

Clients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each client.

Most staff we spoke with found it difficult to give examples of how the service would cater for clients with protected characteristics. For example, most staff could not share what the service would do for clients that spoke another language, had diverse needs in relation to race and sexual orientation. However, one client told us that they had discussed identifying religious services in the local area with their allocated worker. Staff had completed equality and diversity training and had a policy for staff to refer to. We spoke to the manager who highlighted this as a learning need and the service had plans to pursue further, additional training.

We observed a staff handover meeting staff. Staff shared information about clients effectively at the meeting. The service handover happened for every shift. Two of three clients we spoke to said that any concerns they had asked staff to raise in handovers, had been discussed.

Residential substance misuse services

Staff followed policy to keep client information confidential. The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients.

Staff produced a newsletter for clients that included introduction of new starters, donations to the service from local businesses and times and dates of aftercare meetings.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Involvement of clients

Staff involved clients in developing their care plans. Clients we spoke to reported that they met with staff on a monthly basis to review their treatment plans. Staff made sure clients understood their care and treatment.

Staff had conducted a client survey through a questionnaire that covered topics such as feedback on the service's rules and boundaries, the attitude of staff towards clients' recovery and feedback on the workshops provided. Results from the questionnaires showed that clients felt groups were helpful and the rules of Mount Carmel were helpful for their recovery. Clients fed back about activities they did not find helpful.

Staff engaged with clients, their carers and families (where appropriate) to develop responses that met their needs and ensured they had the information needed to make informed decisions about their care.

Staff made sure clients could access advocacy services.

Staff involved clients in decisions about the service, when appropriate. Clients could give feedback on the service and their treatment and staff supported them to do this through weekly house meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately. For example, some privately funded clients invited families to feedback on the service and discuss further funding during informal sessions. Some clients opted not to involve their family or friends and preferred their treatment to remain confidential.

Are Residential substance misuse services responsive?

Good 

We rated responsive as good.

Access and waiting times

Residential substance misuse services

The service was easy to access. The service had clear criteria to describe which clients they would offer services to. Clients were assessed as soon as they were referred. There had been a reduction in the number of referrals over the pandemic. The criteria for admission included having a primary concern of alcohol addiction and willingness to stop drinking. They did not have a waiting list at the time of the inspection. The service received referrals from different parts of the country, through local authorities and self-referrals.

The service had the capacity for 18 clients. At the time of the inspection the service had 16 clients. The average length the stay in the service was three to six months.

Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet. The service maintained a client discharge check list that included an exit questionnaire, deregistering from the GP and ensuring clients' documents were sent to the correct service.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported clients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. Clients also had access to rooms where they could meet with staff to have confidential discussions.

Clients could personalise their bedrooms and had access to locked storage spaces for their personal possessions. Clients did not have locked storage in their rooms but could access locked storage in other parts of the service to store items.

Staff facilitated groups and activities every day such as sleep hygiene, choir, sound therapy, creative writing, meditation, yoga, mindfulness, group hypnotherapy, accessed equine assisted therapy, dramatherapy, auricular acupuncture, Indian head massage and reflexology.

Meeting the needs of all people who use the service

Staff made sure clients could access information on treatment and how to complain.

Staff reported they could access information leaflets available in languages spoken by the clients and local community, if needed.

Managers made sure staff and clients could obtain an interpreter if needed.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with the team.

The service had not received any formal complaints in the previous 12 months.

Clients knew how to complain or raise concerns if they needed to. The procedure was explained during their induction to the service. The clients we spoke with confirmed this. They told us they felt confident in making a complaint if they wished to.

Residential substance misuse services

Staff knew how to acknowledge informal complaints appropriately and clients received feedback from staff. If necessary, staff escalated the informal complaint to the service manager.

The service had a complaints policy. Clients received information of how to make a complaint in their induction pack as part of their admission to the service.

Managers shared feedback from complaints with staff during handovers. Clients we spoke to felt that any learning from informal complaints seemed to be passed from shift to shift.

The service had used exit questionnaires to evaluate the service. Compliments from those questionnaires and other forms were used to learn, celebrate success and improve the quality of care.

Are Residential substance misuse services well-led?

Good 

We rated Well Led as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles and had a good understanding of the service they managed. They were visible in the service and approachable for clients and staff.

The service manager had a good understanding of the service. The service manager was also the chief executive of the service. They could explain clearly how the team was working to provide quality care. The service manager was able to give a review of the service strengths such as identifying the strengths of different members of staff and identified development opportunities.

The service manager and deputy service manager were visible in the service and approachable for clients patients and staff. The service managers worked on site was in close contact with staff.

Vision and strategy

Staff knew and understood the service's vision and values and how they applied to their work.

The service had clearly defined values. The values included a commitment to abstinent recovery, inclusiveness, a public service ethos, responsiveness, value for money and integrity. The values of the organisation were advertised on the service website.

Culture

Staff felt respected, supported and valued. They reported that the service provided opportunities for career progression. They felt able to raise concerns without fear of retribution. Staff felt that morale was good. The service had furloughed staff during the pandemic, and they had felt supported by management during this period. All staff furloughed during the pandemic had returned to into full time employment.

Residential substance misuse services

Governance

Appropriate systems to evaluate the safety and effectiveness of the service were in place. Governance policies, procedures and protocols were last reviewed in 23 April 2021.

Staff were appraised and received mandatory training. They received monthly clinical supervision sessions with a manager.

Staff completed audits to provide assurance on the performance of the service, such as the health and safety audit and record keeping audit. The record keeping audits we reviewed during the inspection included checking if a risk assessment had been completed, identifying if risk management plans had been completed and action staff needed to take if these had not been done. However, the two risk assessments we found were absent during the inspection had not been identified for the service audit. The medicine audit did not include the expiration of medicines and missing allergies on the medicine administration records that had not been chosen for the audit.

The service had a committee attended by the organisation chairperson, vice-chair, manager, deputy manager, finance and administration manager, and management committee members. The service committee reviewed key performance indicators. These meetings included discussion of community engagement plans, service finances, complaints and compliments, staff appraisals, the percentage of clients successfully completing the programme, the number of safety incidents and complaints and the number of referrals.

The service held personnel and finance sub-committee meetings to discuss referrals to the services, and service costs including staff salaries, and staffing. The sub-committees were attended by the chairman, vice-chair, chief executive/manager, finance and administration manager and select management committee members.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The manager maintained a risk register for the service and knew what was on the register. A range of risks had been identified for example the management of medicines, fire safety and exposure to blood borne viruses. Staff could escalate concerns when required. Risks were identified, and a plan made for each risk on the register. The risk register was reviewed on an annual basis or when there had been any changes in the service.

The service had continuity plans in place in case of an emergency, such as the effects of the COVID-19 pandemic, severe weather and death of a member of the leadership team.

Information management

The service manager had access to information to support them in their management role. For example, HR records, supervision records as well as training data, sickness records and annual leave requests.

Staff had access to the equipment and information technology needed to do their work. For example, they used electrical equipment to facilitate AA groups and meetings with families or carers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <ul style="list-style-type: none"><li data-bbox="815 786 1501 965">• The service must ensure that all medicines are stored safely and securely and are, within expiry date. All medicine administration records must record whether or not a client has an allergy and include the names of staff completing them. Regulation 12(2)(e)<li data-bbox="815 972 1501 1077">• The provider must ensure that clients are able to store their medicines securely in their bedrooms. Regulation 12(2)(e)