

The Hygrove







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?	Requires improvement		
Are services effective?	Good		
Are services caring?	Good		
Are services responsive?	Good		
Are services well-led?	Good		

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated The Hygrove as good because:

- The service had enough staff and had plans in place to adjust staffing levels when client numbers increased. Staff assessed and managed risks well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate client recovery.
- Staff assessed the physical and mental health of all clients on admission. They developed individual care plans which staff reviewed regularly and updated as needed. Care plans reflected clients' assessed needs, and were personalised, holistic and recovery-oriented. Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- Staff provided a range of treatment and care for clients based on national guidance and best practice for substance misuse services from the National Institute for Health and Care Excellence (NICE).
- Staff treated clients with compassion, kindness and respected their privacy and dignity. They had an understanding of the impact care and treatment could have on emotional and social well-being. The design, layout, and furnishings of the service supported clients' treatment, privacy and dignity.
- The service treated incidents, concerns and complaints seriously. They investigated them, learned lessons from the results, and shared these with the whole team and wider service to improve practice.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of

substance misuse and the service they managed. Leaders were visible in the service and approachable for clients and staff. Staff felt respected, supported and valued, and morale was good.

However:

- Systems and processes around administering and recording of medicines were not robust. We found a number of medicines errors during our visit. Medicines management and the related training was the responsibility of the lead nurse and clinical lead, and there was no external monitoring of this. Although the errors we found at the time of inspection carried a low risk, and the service took action to improve practice and learn from errors, we were concerned there was insufficient oversight.
- While the building was clean, well equipped, well-furnished and fit for purpose, there were some maintenance issues to be addressed. These included non-working lifts and irregular access to hot water due to boiler problems.
- Staff training compliance levels were 75% or below for training such as safeguarding and basic life support, as well as some core substance misuse specialist training courses. Although safeguarding was regularly discussed in team meetings and as part of supervision, staff were not confident with their safeguarding responsibilities. Staff would discuss any concerns with their manager or supervisor, who would follow these up with the local authority as appropriate to ensure that people were safe from abuse.

Summary of findings

Our judgements about each of the main services

Service

**Residential
substance
misuse
services**

Rating

Good



Summary of each main service

The Hygrove is a residential substance misuse service providing clinically supervised detoxification and rehabilitation.

Summary of findings

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Good 

The Hygrove

Services we looked at

Residential substance misuse services

Summary of this inspection

Background to The Hygrove

The Hygrove is a 28-bed substance misuse service providing clinically supervised detoxification and rehabilitation to adults using both the 12 steps programme and five ways to wellbeing models. Detoxification is managed by a non-medical-prescriber nurse and pharmacist and the service does not accept referrals of people whose needs they are not competent to meet.

The Hygrove was originally part of Drink & Drug Recovery Ltd, but became an independent entity on registration. The Hygrove is now a part of Abbeycare, alongside two other similar services across the country.

The service is registered for the following regulated activities:

- Accommodation for persons who require treatment for substance misuse.

- Treatment of disease, disorder or injury.

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

The Hygrove is situated in an old building that has been adapted for the service. Clients have access to a wide number of facilities and large grounds. It is not a secure environment and all clients are voluntary. Each client is screened before admission, and criterion for entry are low to medium risk.

Clients self refer for private admissions, although a small number of clients are admitted to the programme with the support of charitable organisations. At the time of the inspection there were seven clients.

This service was registered by CQC on 10 May 2018 and has not been inspected previously.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspection manager and a specialist advisor with a professional background in substance misuse.

Why we carried out this inspection

We undertook an unannounced, comprehensive inspection of this service as part of our routine programme of inspecting registered services.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- looked at the quality of the environment and observed how staff were caring for clients;
- held a focus group with five clients who were using the service and spoke with one client individually;
- spoke with the registered manager and the chief executive;
- spoke with 10 other staff members, five in a focus group and five individually;
- attended and observed a therapy group and a handover meeting;
- looked at six client medicines charts and seven client care records;
- carried out a specific check of medicines management; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients told us that the building was clean and furnished and decorated to a high standard. However, there were some maintenance issues that took some time to resolve. Clients only had access to intermittent hot water due to a problem with the boiler, the lifts to the upper floor were not working and Wi-Fi was unreliable throughout the building. Feedback sheets that had been completed by clients on discharge from the service echoed these concerns.

Clients told us they felt safe and were kept informed about and involved in their care and treatment. Clients and client feedback sheets told us the food was excellent, with the chef catering for all dietary needs and preferences on request.

Clients told us they did not feel there were enough staff to provide therapy sessions when there were a larger number of clients in the programme. They also told us they were expected to slot into a rolling programme despite their varying needs and different stages of the detoxification regime. This was a particular issue for clients who had a short stay detoxification. Some clients also raised concerns about the lack of weekend activities and overall value for money, although not all clients shared this concern.

Client feedback sheets were overall positive about their experience at The Hygrove and the care and treatment they received. They were also very complimentary about the skills and empathic approach of staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as requires improvement because:

- Systems and processes around administering and recording of medicines were not robust. We found a number of medication errors during our visit. Medicines management and the related training was the responsibility of the lead nurse and clinical lead, and there was no external monitoring of this. Although the errors we found at the time of inspection carried a low risk, and the service took action to improve practice and learn from errors, we were concerned there was insufficient oversight.
- While the building was clean, well equipped, well furnished, and fit for purpose, there were some maintenance issues including non-working lifts and irregular access to hot water due to boiler problems. An engineer had visited the previous day to look at the lift but no date had been confirmed for repairs to be completed, and plans were in place to replace the boilers in the summer.
- The service provided mandatory training in key skills for all staff, but staff compliance levels were 75% or below for key training such as safeguarding and basic life support, as well as some core substance misuse specialist training courses.
- Staff were not confident with their responsibilities for safeguarding. Not all staff had accessed the available safeguarding training.

However:

- The service had enough staff, who knew the clients well. The service did not have any medical staff, and clinical staff were limited to an on-site lead nurse and non-medical prescriber who prescribed all detoxification medicines and an off-site clinical lead pharmacist. The service did not accept referrals of people whose needs they were not competent to meet. The service had plans in place to adjust staffing levels when client numbers increased.
- Staff assessed and managed risks well. They responded promptly to deterioration in a client's health and wellbeing. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate client recovery.
- Staff kept detailed records of clients' care. Records were clear, up-to-date and easily available to all staff providing care.

Requires improvement



Summary of this inspection

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

Are services effective?

We rated effective as good because:

- Staff assessed the physical and mental health of all clients on admission. They developed individual care plans which were reviewed regularly and updated as needed. Care plans reflected clients' assessed needs, and were personalised, holistic and recovery-oriented.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. These included use of the clinical institute withdrawal assessment for alcohol (CIWA-AR) and the modified early warning score (MEWS) to identify any deterioration in physical health. They also participated in clinical audit and quality improvement initiatives.
- Managers supported staff with supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff supported clients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005 and were aware of the fluctuating nature of capacity and the potential impact of substance misuse on the ability to make a decision.

Good



Are services caring?

We rated caring as good because:

- Staff treated clients with compassion and kindness. Staff had an understanding of the impact peoples' care and treatment could have on their emotional and social well-being. They respected clients' privacy and dignity. They understood the individual needs of clients and supported them to understand and manage their care, treatment or condition.
- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided.
- Staff informed and involved families and carers appropriately, including holding fortnightly family therapy groups.

However:

Good



Summary of this inspection

- Staff were unfamiliar with the role of advocacy services, and would not be able to ensure that clients who would benefit from independent advocates had access to this support.

Are services responsive?

We rated responsive as good because:

- The service was easy to access. Its referral criteria did not exclude clients who would have benefitted from care. Staff assessed and treated clients who required care promptly and clients who did not require urgent care did not wait too long to start treatment.
- Staff planned and managed discharge well from the day of admission.
- The design, layout, and furnishings of the service supported clients' treatment, privacy and dignity. Each client had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and clients could make hot drinks at any time.
- Staff supported clients with accessing activities in the local community.
- The service treated concerns and complaints seriously. They investigated them, learned lessons from the results, and shared these with the whole team and wider service.

Good



Are services well-led?

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible and approachable for clients and staff.
- Staff knew and understood the provider's vision and values and how they applied to the work of their team.
- Staff felt respected, supported and valued, and morale was good amongst the team.
- Staff collected and analysed data about outcomes and performance.
- The service had been proactive in responding to incidents and errors, and had made changes to improve practice as a result.

Good



Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

The service had a policy on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which staff were aware of and could refer to. Staff referred any concerns around mental capacity to the registered manager.

Staff were aware of the potential impact of substance misuse on mental capacity. They knew that this could lead to fluctuating capacity, and the need to delay decisions until such time as a person was no longer under the influence of substances and was able to make the decision for themselves.

People were supported to make decisions where appropriate. When they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Staff ensured clients consented to care and treatment. Staff assessed capacity to consent to treatment as part of the admission process. Clients would sign a contract consenting to the treatment programme. The service would not admit clients who lacked capacity to consent to the programme, but were aware that capacity to consent could change, and that this needed to be an ongoing consideration.






Staff had access to Mental Capacity Act 2005 online learning as part of their basic induction training.

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 

Safe and clean environment

The service had accessible rooms where staff met with clients. The building was situated over three floors, and all therapeutic group work took place on the third floor. At the time of the inspection, the two lifts in the building had been out of use for a few days and were awaiting repair. An engineer had visited the previous day but no date had been confirmed for repairs to be completed as a result of waiting for ordered parts to be delivered. As such clients with mobility issues would have been unable to access these rooms safely.

Due to the age and design of the building, there were many blind spots and ligature risks. The provider mitigated against these through risk assessment and observation. The service also did not admit clients who were considered to be at high risk of self harm. The provider had a thorough environmental risk assessment in place that included ligature risks and steps taken to mitigate these.

Areas that clients using the service had access to were clean, comfortable and well maintained. Furniture and décor were in good condition throughout the building and clients had access to spacious, well-kept grounds and gardens. Staff kept up-to-date cleaning records, maintenance logs and fire safety assessments and plans were in place. However, we were told there had been problems with the boiler which had broken down the

previous weekend for three days. The provider was planning to replace the boiler that was not sufficient to cover hot water and heating for the whole building in the summer.

Staff were issued with personal alarms as needed.

Clients in the early stages of detoxification who needed additional support or monitoring would stay in a room downstairs where they could be more closely monitored and summon assistance more easily.

There was an open building used by maintenance staff next to the house which contained harmful fluids not stored in a locked cupboard. We brought this to the attention of the provider who addressed the situation and removed these during the inspection.

Staff adhered to infection control principles, including handwashing and the disposal of clinical waste.

Safe staffing

The provider had enough staff to meet the clients' needs, and had contingency plans and cover arrangements to manage unforeseen staff shortages to ensure client safety. The provider employed sessional staff, and would also use agency staff to cover any absences as needed.

An experienced non-medical-prescriber nurse managed all detoxification and physical health input with the support of an off-site clinical lead, who was a non-medical-prescriber and pharmacist.

There was no external oversight of medicines other than a bimonthly clinical governance meeting, and no medical input. The Hygrove did not have a consultant psychiatrist as part of the team. As such this was not part of the ongoing support offered as part of the clinically monitored

Residential substance misuse services

detoxification. However, staff did have access on an exceptional basis to a consultant employed by the Abbeycare group. The service could also access the support of local GP services.

The service had access to on call nursing support on a 24 hour basis and waking night staff would summon assistance as needed.

The service did not accept clients assessed as high risk or with complex care needs whose needs could not be met without medical monitoring.

Clients and staff raised concerns about the level of staffing, and felt that while it was sufficient with the client numbers at the time of the inspection, if these numbers were to increase further this would impact on the availability of staff to carry out a full and effective therapeutic programme. The provider had placed a limit on 16 clients at the present staff level, and acknowledged that if client numbers increased beyond this, additional staff recruitment would be needed.

Staff were not all up to date with the provider's core mandatory training. Staff completed a series of training as part of their induction. Staff who joined the service on registration in April/ May 2018 attended a safeguarding seminar as part of this induction. Staff could also access additional online safeguarding training.

At the time of the inspection the training matrix identified that only 16 out of 28 members of staff listed on the matrix had attended this training. Eight members of staff had been recorded as having completed basic life support and first aid training, 14 had completed fire safety training, four had completed suicide awareness training, seven had completed sexual health training, and seven had completed naloxone training. Ten staff had completed medicines and detoxification training, and all staff members involved in administering medicines had completed competency for medicines administration training. No staff had completed the EpiPen, midazolam or blood borne virus training. However, many of the staff were new in post and further mandatory training dates had been booked for these staff to attend. It must also be acknowledged that not all training would be relevant for all staff to complete as part of their roles. For example,

domestic staff would not be expected to complete medical or psychosocial training. As such compliance figures did not accurately represent the proportion of staff who had completed mandatory training.

The registered manager acknowledged that staff training had been an area in need of improvement, but that training provision had improved since the service had obtained access to Abbeycare training resources.

Assessing and managing risk to patients and staff

We looked at seven care records and found them to be of a good standard, with up-to-date information, personalised, holistic and recovery orientated assessments and care plans.

Staff carried out basic risk assessments as part of the pre-admission assessment to ensure that clients were low to medium risk and that their needs could be met within the service.

Staff worked with clients to create and make good use of crisis and risk management plans. Staff identified and responded to changing risks posed by clients by updating their risk assessments and risk management plans. One client who had experienced a deterioration in health was being provided with additional staffing support to meet their identified needs.

Staff did not complete early exit from treatment plans with clients, but worked with them from admission to prepare for discharge, whether this was on the planned date or at any time before or after this. As such if a client were to leave early then a plan would already be in place for them on discharge.

Staff made clients aware of the risks of continued substance misuse, and gave harm minimisation advice and information throughout the programme. Safety planning was an integral part of discharge planning.

The service had a designated smoking area.

The service had a list of banned articles to facilitate detoxification from substances and to reduce client risks. Clients were not permitted to leave the grounds in the first seven days of detoxification and were asked to leave their mobile phones in the care of staff for the first four days,

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although could request to use during this time if they wished to. Clients were made aware of these restrictions pre-admission and were asked to sign to consent to these on admission.

Safeguarding

Safeguarding systems were in place but it was unclear how robust these were. Staff had access to online training on safeguarding adults and children and some staff had attended a safeguarding seminar as part of their induction. Not all staff had accessed safeguarding training, but were aware that there were plans in place for this to happen. While the registered manager was confident that staff were proficient in safeguarding, this confidence was not shared by staff we spoke with, who felt uncertain about their role and responsibilities for safeguarding. Safeguarding was a standing agenda item in team meetings and supervision, and staff discussed any possible safeguarding concerns with the registered manager. The manager would then discuss any safeguarding concerns with the local authority as needed to ensure people were safe.

Staff access to essential information

Relevant staff had prompt and appropriate access to care records that were accurate and up-to-date.

Staff used paper records only for client assessments and care plans. There were no plans to move to a computerised system.

Medicines management

Medicines were overseen by a non-medical prescriber nurse in the team with support from a clinical lead pharmacist who was also a non-medical prescriber. The clinical lead provided support on an on-call basis when the nurse was unavailable. When the lead nurse was on leave agency nurses were brought in to cover any medicines management.

The nurse prescribed all detoxification medicines. Recovery staff administered these medicines after having been given internal competency training, signed off by the nurse on site.

The service had identified a number of medicines errors over the past few months. The manager and nurse had investigated these errors and had identified them to be low risk and no harm sustained. However, the errors were varied, and included administration and recording errors.

The service was able to demonstrate improvements that had been made to medicines management as a result of investigations into errors. This included adding client photographs to the front of medication administration records (MARs) following a client having medicines administered from another client's MARs sheet. We were told that there had been a significant reduction in medicines errors in the past couple of months but that there had been a further two errors in the week before the inspection.

Track record on safety

There had been four serious incidents reported in the 12 months before the inspection. These included two incidents of clients leaving the grounds and taking substances while absent, and one incident of client self harm. Following the investigation into an incident where a patient had an epileptic seizure in bed earlier this year, the registered manager bought epilepsy monitors and established an individual seizure monitoring protocol for the client.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported incidents that they should report. If they were uncertain they would seek advice from the registered manager.

Staff understood the duty of candour. They were open and transparent, and gave clients and their families (where appropriate) a full explanation if and when something went wrong.

The registered manager provided information about improvements in safety and practice following incidents, and was able to demonstrate the process for investigating and learning from incidents.

Are residential substance misuse services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

Residential substance misuse services

We looked at seven care records. We found each of these to be of a good standard, including holistic, person centred, recovery focused assessments and care plans.

Staff completed a comprehensive assessment in a timely manner. All clients had a pre-admission assessment by phone including an assessment of clinical and psychosocial needs and current risks. This information was shared with the lead nurse who requested medical summaries, including blood results from the GP. Clients would not be admitted until the service had received this summary. The nurse completed a more detailed face-to-face assessment on the day of admission before clients were formally admitted, including a physical health check. The nurse monitored clients' physical health on a daily basis, including taking basic observations.

We were given an example of a client whose presentation and needs on arrival at the service were different to those identified within the pre-admission assessment. While the service were aware of the mobility needs, the information gathered and provided during the pre-admission assessment process did not fully reflect the situation. As a result further assessment determined that the client's needs could not be met and their treatment was cut short as a result. While arranging discharge the service organised additional staffing to meet the client's needs and worked with the family and care providers to arrange a safe discharge.

Staff developed care plans that met the needs identified during the initial assessment. Staff reviewed individual needs and recovery plans, including risk management plans as needed, and updated care plans when necessary.

Staff developed a risk management plan for those people identified as being at risk. This did not include a specific plan for unexpected exit from treatment, but plans for discharge were started from admission. As such if a client chose to leave early, they would already have a discharge plan in place.

Best practice in treatment and care

We looked at seven care records. Staff recorded the use of risk assessment and outcome measure tools such the CORE34 risk assessment and the clinical institute withdrawal assessment for alcohol (CIWA-AR). There was no

evidence of assessment of blood borne viruses or harm reduction advice. However, the manager told us that harm reduction advice was part of the ongoing therapy programme.

Staff carried out and recorded ongoing physical health assessment and care. This included a physical health assessment on admission and use of the modified early warning score (MEWS) to identify any deterioration in physical health.

Staff provided a range of care and treatment interventions suitable for the client group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). These included detoxification medicines and a rolling programme of psychological therapies. Clients were involved in their care and treatment, and were given harm reduction information and advice throughout the programme.

The service identified and embedded relevant and current evidence based practice and guidance, for example NICE guidance and National Treatment Agency for Substance Misuse (now part of Public Health England) tools to provide quality care.

The service offered therapeutic interventions in line with the 12-step programme, a recognised series of guiding principles for recovery from addiction. The service also worked within the five ways to wellbeing model, for developing and supporting mental wellbeing.

Staff offered clients access to blood borne virus testing as part of the initial assessment and admissions process. However, there was no recorded evidence of blood borne virus testing taking place in the client records. The service had recently made blood borne virus training available for staff, but at the time of the inspection no staff members had completed this.

Staff supported clients to live healthier lives. Clients had access to a nutritionist once a week, and a personal trainer. They could also access the onsite gym equipment and the service was in the process of arranging for ongoing alternative therapies to be offered as part of the programme.

Monitoring and comparing treatment outcomes

Residential substance misuse services

Staff regularly reviewed the care and recovery plans with clients to ensure they continued to be relevant and fit for purpose.

Skilled staff to deliver care

The service had a range of professionals within the team to meet the clients' basic needs. The service included a nurse (non-medical prescriber), clinical lead (pharmacist and non-medical prescriber), counsellors, recovery practitioners and senior recovery practitioners, a nutritionist and personal trainer. In addition to this the service had catering and domestic teams and a maintenance manager. However, the service did not have access to internal consultant support except on an exceptional basis. Clients registered with local health services on a temporary basis while they were in treatment.

The service provided all staff with a comprehensive induction that included mandatory training, shadowing and an extensive range of policies and procedures.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Training and development was a standing supervision agenda item and all staff who did not have a national vocational qualification (NVQ) were supported to enrol and study for this. However, while the service had a mandatory training matrix, and made training available for staff, not all staff had completed this. Some staff highlighted key gaps in their training to us, including not having attended safeguarding or Mental Capacity Act 2005 training.

The service ensured that robust recruitment procedures were in place and followed, and any poor staff performance was dealt with within performance management policies.

All staff received regular supervision from appropriate professionals. The service had been open less than a year so no appraisals had taken place.

The service did not have any volunteers.

Multi-disciplinary and inter-agency team work

Where appropriate, recovery plans included clear care pathways to other supporting services. The service worked with health, social care and other agencies to plan integrated and coordinated pathways of care to meet the needs of different groups. We were given an example of a

client who had some ongoing care needs prior to his planned discharge. The service linked in with the local authority social work team to explore their options in preparation for their discharge.

The service discharged people when specialist care was no longer necessary (generally at the planned end of the 28-day programme), and worked with relevant supporting services to ensure the timely transfer of information.

Good practice in applying the MCA

The service had a policy on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which staff were aware of and could refer to. Staff referred any concerns around mental capacity to the registered manager.

Staff were aware of the potential impact of substance misuse on mental capacity. They knew that this could lead to fluctuating capacity, and the need to delay decisions until such time as a person was no longer under the influence of substances and was able to make the decision for themselves.

People were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Staff ensured clients consented to care and treatment. Staff assessed capacity to consent to treatment as part of the admission process. Clients would sign a contract consenting to the treatment programme. The service would not admit clients who lacked capacity to consent to the programme, but were aware that capacity to consent could change, and that this needed to be an ongoing consideration.

Staff had access to Mental Capacity Act 2005 online learning as part of their basic induction training.

Are residential substance misuse services caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

Residential substance misuse services

Observations and reports (by clients during treatment and in feedback post discharge) of staff attitudes and behaviours when interacting with clients, demonstrated compassion, dignity and respect. Staff provided responsive, practical and emotional support as appropriate.

Staff supported clients to understand and manage their care, treatment or condition. Staff directed clients to other services when appropriate, and, if required, supported them to access those services.

Staff demonstrated an understanding of the potential issues facing vulnerable groups. Clients told us staff showed empathy towards them. Some staff had experienced their own recovery journeys and were able to draw on this experience to provide clients with skilled and knowledgeable support.

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

Involvement in care

Staff communicated with clients so that they understood their care and treatment. All clients were allocated a buddy (a client who had already been in the programme for two to three weeks), and given a welcome pack to orientate them to the service. All new starters to the programme would attend a welcome and induction session led by the registered manager.

Staff offered clients access to advocacy as part of the admission process, and this was recorded in the admissions checklist. The service had access to details about local advocacy for clients, but had not made any referrals to this service. Staff were however unclear about the role of advocacy.

Each client had a recovery plan and risk management plan in place that demonstrated their preferences, recovery capital and goals. Each client had been recorded as having been given or offered a copy of this plan. All clients detoxing from opiates were given naloxone and naloxone training for discharge if they wished for this. Naloxone is a non addictive drug that can be used to reverse the effects of an opiate overdose.

Staff actively engaged clients (and their families/ carers where appropriate) in planning their care and treatment. Clients wrote their care plans with their keyworkers, and used their own goals to shape their discharge and aftercare plan.

Staff enabled clients, families and carers to give feedback on the service they received. Clients had weekly peer forum meetings, where a client acting as house leader would lead the meeting and complete a feedback form for the service. This form would be reviewed as part of a community meeting later that week. Clients also completed feedback forms on discharge. The manager had set up a feedback database to ensure this information was captured and to look for any overarching themes that needed to be addressed to improve the service. The service also had a “you said, we did” board in the lounge to show responses they had made to previous feedback.

Staff provided carers with information on how to access a carer’s assessment if they wished to do so, although this was only done occasionally. The service encouraged family visits on a weekend, and held a fortnightly carers’ therapy group, which had not been running for long, but was well attended.

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

Good 

Access and discharge

The service had clear admission criteria, and would only accept clients over the age of 18, with a substance addiction, and considered to be low or medium risk. The service would not accept clients with severe or clear undiagnosed mental health issues, or with a history of sexual offences or arson. The service also would not accept clients with severe liver function damage due to the specialist physical health care skills needed to support clients with this condition.

The service did not have a specific agreed response time for referrals, but were able to admit the majority of referrals within 24 hours, and had previously admitted a client within three to four hours of them making contact.

Residential substance misuse services

Admissions were only delayed if there was a delay in accessing medical reports pre-admission or if there were concerns about liver functioning and additional tests were requested.

Recovery and risk management plans reflected the diverse or complex needs of clients, including clear care pathways to other supporting services where this was appropriate, for example, housing, social care needs or mental health support.

The service did not take external referrals from commissioners, as all clients were privately funded for the treatment programme.

Staff planned for clients' discharge from the start of their admission. Clients were given a graduation ceremony on the day of discharge to celebrate their achievements during the treatment programme. Staff did not routinely work with external agencies as part of the discharge planning and process as this was not relevant to many of the service's clients, who rarely had additional external support agencies involved.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had their own bedrooms and were not expected to sleep in bed bays or dormitories. There was no segregation of male and female rooms, but all bedrooms had en-suite facilities. There was an additional bathroom located on each floor. All clients had a key to their own room, and there were no limitations as to when they could access their rooms, other than an expectation of attending the therapeutic groups. Bedrooms varied in size, and clients could select larger rooms for an increased cost.

Clients shared access to lounges. Clients could make hot drinks in the lounge throughout the day. There were a variety of interview rooms available, and a large amount of space on the lower and upper floors for therapy. Although therapy groups were generally held on the third floor, there was an available group room on the ground floor. Clients also had access to a gym, sauna and hot tub on site, as well as access to the grounds.

Patients' engagement with the wider community

Staff supported clients to maintain contact with their families and carers. Staff encouraged family visits and clients could go out locally with their families.

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

Staff encouraged access to the local community and activities. Staff facilitated visits to the local farm once every four weeks, as well as taking clients on local walks, rock climbing, to events at the local village hall, and to the local church or mosque. Staff also supported clients to attend local alcoholics anonymous (AA) or narcotics anonymous (NA) meetings as part of their introduction to the 12-step recovery programme.

Meeting the needs of all people who use the service

The service had accessible bathrooms throughout, with access ramps at the front and rear of the building. However, the lifts were broken at the time of the inspection and so clients with mobility issues could not access the upper floors. One client with mobility problems had been unable to access the upper floor therapy rooms due to the lifts not working. On this occasion staff temporarily switched therapy groups to a ground floor group room to ensure that all clients could access the groups. The service had made adjustments to the accessible bathrooms for a client with mobility problems to ensure the floor was non-slip, and that there were additional handrails in place as needed.

Clients had meal choices. If they had any particular dietary needs, the chef provided meals to meet these. The service also had a multi-faith room with a range of different religious artefacts to meet the needs of a range of different faiths. Staff also facilitated visits to local places of worship. Leaflets were available to download in a range of languages.

The service did not have any waiting lists to monitor. Clients were admitted to the programme as soon as they had been accepted and following receipt of the requested medical information.

Clients reported that care and treatment was not cancelled or delayed.

Listening to and learning from concerns and complaints

Staff protected clients who raised concerns or complaints from discrimination and harassment. Complaints records demonstrated that individual complaints were responded to in accordance with the service's complaints policy.

Residential substance misuse services

The service had a clear complaint system to show how complaints were managed and lessons were acted upon to improve the quality of the service.

Are residential substance misuse services well-led?

Good 

Leadership

Leaders provided clinical leadership, and had the skills, knowledge and experience to perform their roles. The registered manager was in the process of completing a Level 5 NVQ in Health and Social Care with support from the organisation. Leaders from Abbeycare also spent time at the service, embedding policies, procedures and ways of working into the service. They were visible in the service and approachable for clients and staff.

The organisation had a clear idea of recovery, working within the five ways to wellbeing framework since the start of the service. However, since joining Abbeycare, the 12 steps to recovery model was introduced and used alongside the previous model.

Leaders had a good understanding of the service they managed. They could explain clearly how they were working to provide high quality care.

Vision and strategy

Staff knew and understood the visions and values of the team and organisation and what their role was in achieving that. Staff were part of the discussions around the visions and values when the service merged with Abbeycare, acknowledging that this would lead to a change in culture, the service agreed a balance between the 12-step and the five ways to wellbeing models.

Culture

Staff felt respected, supported and valued. The staff group felt positive, satisfied and while the service had been through a number of changes since opening that had created challenges for the staff group, they now had low levels of stress. Morale in the team was good and the service was more settled.

The provider recognised staff success within the service, and had employee of the month awards.

Staff felt valued and part of the organisation's future direction. They felt positive and proud about working for the provider and their team and had confidence in the management team.

The service had been open less than a year so no staff had received an appraisal at the time of the inspection.

Staff knew the service's whistleblowing policy. The service responded to any concerns around staff performance and where there were difficulties within the team the manager investigated these and followed them up.

Governance

The service had systems and processes to ensure the service was safe and clean, with the exception of the safe management of medicines. The service had sufficient staff at the time of the inspection for the number of clients in the service, although acknowledged this would need to increase as clients numbers changed. Clients were assessed over the telephone initially, which had led to an issue with an understated mobility problem with a recent client admission, and brought into question the effectiveness of this system. Staff had regular supervision and training available to them, but leaders had not ensured that staff had all attended core training. The registered manager acknowledged that training had been an issue, but that this was an improving picture. The manager had scheduled additional core training to ensure that staff all attended this. Discharges were well planned from the time of admission, and incidents were reported, investigated and learnt from.

Governance policies, procedures and protocols had been adopted from the Abbeycare model. These were regularly reviewed to ensure they were relevant and up to date. However, some policies adopted from Abbeycare had not been amended to reflect that they had been adopted by The Hygrove, and referred to other services within the group.

There was a clear framework of what must be discussed in team meetings, to ensure that essential information, including learning from incidents and complaints, was shared and discussed.

Staff had implemented recommendations from reviews of incidents and complaints at the service level. For example,

Residential substance misuse services

the addition of client photographs to medicines administration (MARs) sheets following the incident where a client was administered medicines from the wrong client's sheet.

Staff undertook or participated in local clinical audits. The audits provided some assurance and had picked up some medication errors that led to changes in practice. Staff acted on the results of these when needed.

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

Management of risk, issues and performance

There were quality assurance management and performance frameworks in place integrated across all organisational policies and procedures. Staff maintained and had access to the risk register at facility level, staff at facility level could escalate concerns as required. Staff concerns matched those on the risk register.

The service had contingency plans for emergencies.

Information management

All information needed to deliver care was stored securely and available to staff in an accessible form, when they needed it. The service used systems to collect data that was not over-burdensome for frontline staff. Staff had access to the equipment and information technology they needed to do their work. All client records were paper based.

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Information governance systems included confidentiality of client records.

The registered manager had access to computerised records and spreadsheets in relation to the running of the

service to support with the management role. This included information on the performance of the service, staffing and client care. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Engagement

Staff, clients and carers had access to up-to-date information about the work of the provider and the services they used. Each client was given information in the form of a welcome pack on arrival. Information was also delivered as part of community meetings and during group sessions.

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. All clients were encouraged to give feedback as part of weekly peer forums and community meetings, as well as feedback sheets at the point of discharge.

Clients and staff could meet with members of the provider's senior leadership team to give feedback.

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence based practice was implemented and embedded. The service was not involved in any research at the time of inspection. Staff were keen to deliver a range of holistic and alternative therapies tailored to the individual wishes and needs of clients, including acupuncture, African drumming, tai chi, yoga and Tibetan singing, bowls and chimes to support with meditation. Clients had the option to work with the holistic therapist on a one to one basis.

All staff had objectives focused on improvement and learning, and the service had a staff awards and recognition scheme.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that all staff receive appropriate training, support and monitoring to ensure they are sufficiently competent to safely and effectively administer medicines (Regulation 12).
- The provider must ensure there are robust systems in place to provide sufficient oversight of medicines management to ensure medicines are safely dispensed and administered (Regulation 12).
- The provider must ensure that all clients have access to a reliable and consistent hot water supply (Regulation 15).

- The provider must ensure that all staff attend and complete mandatory training (Regulation 18).

Action the provider **SHOULD** take to improve

- The provider should ensure that all clients have access to working lifts.
- The provider should review the initial assessment process to ensure they have a comprehensive assessment of basic needs before admission to the service.

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 Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe Care and Treatment.</p> <p>Staff who administered medicines were trained and assessed as competent by an internal staff member. There was no external oversight of this process. Staff administering medicines were involved in a number of medicines errors.</p> <p>This is a breach of regulation 12(2)(c)</p> <p>Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.</p> <p>There were a number of different types of medicines errors identified during the inspection. The provider had taken action to respond to these and this was an improving picture, but medicines errors were continuing.</p> <p>This is a breach of regulation 12(2)(g)</p> <p>The proper and safe management of medicines.</p>
Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 15 Premises and Equipment.</p> <p>Clients did not have access to a reliable and consistent hot water supply.</p>

This section is primarily information for the provider

Requirement notices

This is a breach of regulation 15(1)(e)

All premises and equipment used by the service provider must be properly maintained.

Regulated activity

Accommodation for persons who require treatment for substance misuse

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing.

Staff had not all attended and completed mandatory training.

This is a breach of regulation 18(2)(a)

Persons employed by the service provider in the provision of a regulated activity must receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform.