Francis House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Outstanding
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 Francis House good because:

- Clients who used this service were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. The service had a strong recovery ethos with staff devoted to ensuring that clients had excellent outcomes. Clients praised the staff in helping them open-up and talk about areas of their life they had previously kept to themselves.
- Staff were highly motivated and inspired to offer care that was kind and promoted clients' dignity. Staffing levels were safe and there were plans in place to cover vacancies, sickness and annual leave. There was a positive culture within the house, staff felt respected and valued as members of the team and there was support from the registered manager. Staff received supervision and an annual appraisal.
- Staff had good knowledge of safeguarding procedures that helped them protect vulnerable adults from abuse. Staff reported incidents as they arose and learnt from accidents and incidents in the house.
- The service provided care based on National Institute for Health and Care Excellence guidance. Both one to one time and group work was provided. Staff monitored and addressed physical health of clients in the house. Staff received mandatory and specialist training and they had a good understanding of the Mental Capacity Act.
- Francis House was visibly clean and there were arrangements in place to ensure the service was kept clean and tidy. The manager completed environment health and safety checks, this included an assessment of ligature points.
- There was no waiting list for the service. In the event of clients relapsing, staff tried to work around triggers for relapse. The service had a range of rooms for clients, including living rooms, a large dining room and a multi-faith room. There was wheelchair access and access to outside space. Staff provided care according to ethnic, cultural differences and personal preferences. Staff supported clients to access and attend external support groups.
- Clients knew how to complain. Policies were in place to guide staff within their work. Managers and staff conducted audits. The provider maintained and discussed the organisational risk register. Clients had regular opportunities to give feedback about the service, including; house meetings, evaluation forms, suggestion box and a feedback book.

However:

- Staff did not complete comprehensive risk assessments for clients admitted to the service and there was no evidence of crisis planning. Staff did not complete individualised care plans for clients accessing the service. Staff did not document discharge plans. Staff kept a lot of information in their heads and this was not translated into the documentation. There were blanket restrictions in place.
- Medicines were not always prescribed safely due to staff not using medicines reconciliation processes as routine. This means that staff did not routinely check that the medicines they were giving were the ones prescribed by the GP.
- The service did not have sufficient governance systems in place to ensure sufficient oversight and risk management of incidents and safeguarding. Managers therefore did not monitor to look for trends, this meant that if the same incident kept on occurring then there was no oversight to look at the reasons why or for example, if there was a gap in staff training.

Summary of findings

Contents

Good

Francis House

Services we looked at;
Substance misuse services

Summary of this inspection

Background to Francis House

Francis House, in Southampton, is one of three substance misuse residential rehabilitation and detoxification services provided by Streetscene Addiction Recovery Service.

Francis House has 18 beds and offers a 24-hour service for males and females. Clients receive treatment for substance misuse problems. There were 14 clients receiving treatment at the time of our inspection. The majority of the funding arrangements are through statutory organisations. However, the service does accept self-funders.

At the time of the inspection there were six clients receiving treatment for substance misuse problem at Francis House.

Francis House has been registered with the Care Quality Commission since 20 January 2011. The service is registered to provide accommodation for persons over 18 years of age who require treatment for substance misuse. There is a CQC registered manager in place.

The previous inspection was in February 2016 where the service was not rated. There was no breach of regulations at that inspection.

Our inspection team

The team that inspected the service comprised three CQC inspectors (one with significant professional experience of working in substance misuse services).

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from clients at three focus groups.

During the inspection visit, the inspection team:

- visited Francis House, looked at the quality of the house environment and observed how staff were caring for clients;
- spoke with all of the clients who were using the service;
- spoke with the registered manager
- spoke with staff members including support workers and therapy workers
- looked at six care and treatment records of clients:
- 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.

Summary of this inspection

What people who use the service say

Clients said that the staff were committed to helping them turn their lives around and that they saved their lives. We heard that all clients were grateful for the opportunity to be supported by the staff at the house and be treated like a family. They were consistent in saying Francis House was amazing and that decisions and support came from a caring place, staff were always nice and encouraging.

Clients praised the staff in helping them open-up and talk about areas of their life they had previously kept to themselves. Staff taught them to be truthful and honest as well as being taught to take care of themselves physically and emotionally. Clients felt respected by staff and they understood changes of emotion such as getting angry and wanting to leave. We heard of several stories where the service had gone over and above helping clients, such as those physically unwell and with nowhere to go.

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?

Requires improvement 

We rated safe requires improvement because:

- Staff did not document comprehensive risk assessments for clients admitted to the service and there was no evidence of crisis planning. We reviewed five care records for clients at Francis House and there was a lack of detail to inform staff of clients' risks. Staff told us that they kept a lot of client information in their heads but this was not translated into documentation.
- Medicines were not always prescribed safely due to staff not using medicines reconciliation processes as routine. This means that support workers transcribed medicines from the boxes that clients brought in with them on admission, there was no standard double checking of the charts or routine contact with the clients GP to ensure that medicines brought in were ones that had been prescribed.
- Despite the service reviewing blanket restrictions there were still a number that remained in place. This meant that restrictions affecting someone in the house were not individually assessed, for example, access to a phone.

However:

- Francis House was visibly clean and there were arrangements in place to ensure the service was kept clean and tidy. Clients staying at the service were taught by staff and peers to clean and tidy the communal areas of the house as well as their own bedrooms. Clients had a bedroom and most of the rooms were en-suite. Staff admitted a client into a shared bedroom if they were having an assisted withdrawal.
- The manager completed environment health and safety checks, this included an assessment of ligature points. Staff adhered to infection control principles such as hand washing and disposing of clinical waste. The service had a de-choking device, ventilated pillows and an automated external defibrillator (AED) for use in emergencies.
- Staffing levels were safe and there were plans in place to cover vacancies, sickness and annual leave. The service had a low sickness and turnover rate. Volunteers and recovery champions were part of the team. Staff kept up to date with mandatory training.

Summary of this inspection

- The care records held plans for unexpected exit from treatment plans and staff described how they supported clients who wanted to leave. Care records showed that there was prior agreement of where a client would go if they left treatment early.
- Staff reported incidents on a paper record and met together to discuss and learn from incidents. Staff described a supportive team around incidents and that they felt confident in managing incidents such as rule breaking or violence and aggression.

Are services effective?

Good

We rated effective as good because:

- Staff completed care plans with clients shortly after their admission. Staff demonstrated an understanding of the individual needs of clients.
- Therapeutic groups addressed the needs of the clients and supported them in their recovery journey.
- The provider followed national best practice guidelines treatment such as National Institute for Health and Care Excellence guidelines (NICE). Staff we spoke with told us they used the Department of Health drug misuse and dependence UK guidelines on clinical management (also known as the 'Orange Book').
- Staff enabled clients to access physical healthcare including GPs, dentists, physiotherapists and hospital appointments.
- Staff had regular supervision and appraisals and attended weekly team meetings.
- Staff had been trained in and understood the Mental Capacity Act.
- The service had provided specialist training for staff to enable them to deliver therapeutic interventions such as, cognitive behavioural therapy, harm reduction, family therapy and motivational interviewing.

However:

- While staff completed care plans they were not always individualised. Care plans were generally generic templates with names added.

Are services caring?

Outstanding

We rated caring as outstanding because:

- Clients who used service were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered people who used the service to have a voice and to realise their

Summary of this inspection

potential. They showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care was delivered.

- The service had a strong recovery ethos with staff devoted to ensuring that clients had excellent outcomes. The service put clients at the heart and staff consistently stated that they were there to support them and help them change their lives.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted clients' dignity.
- Clients praised the staff in helping them open-up and talk about areas of their life they had previously kept to themselves. They were supported to be truthful and honest as well as being supported to take care of themselves physically and emotionally.
- Clients participated in a football competition called the Unity Cup set up by the company and invited local recovery services to join and bring a team. The manager stated Francis House normally won.
- Involvement of clients and families occurred to the very end of their stay at the service. Staff held a graduation ceremony for clients when they completed treatment. Staff, clients, family and friends were invited to attend and celebrate their achievements.

Are services responsive?

Good

We rated responsive as good because:

- There was no waiting list for the service. Staff screened and assessed referrals for suitability. The admissions manager assessed clients and discussed with the manager before agreeing admission.
- In the event of clients relapsing, staff tried to work around triggers for relapse or supported them to transfer to another service rather than discharging them. The provider offered supported living and aftercare to support clients with their recovery journey following discharge.
- The service had a range of rooms for clients, including living rooms, a large dining room and a multi-faith room. Clients had private spaces to make telephone calls from. Bedrooms were individual and shared rooms with an en-suite bathroom.
- Staff supported clients to access and attend external support groups such as Alcoholics Anonymous and Narcotics Anonymous. Day trips were organised for the clients.

Summary of this inspection

- The house was wheelchair accessible and the service was able to respond to different physical and mental health problems as well as cultural differences and spiritual and personal preferences.
- The service provided aftercare. Clients accessed 10 days of treatment in the house following discharge to facilitate the transition from treatment back into the community. The clients also had access to lifelong aftercare through the provider's supported housing provision.

However:

- Staff did not document discharge plans. None of the client care records we reviewed contained a discharge plan, however, staff were aware of the discharge arrangements for clients.

Are services well-led?

Good

We rated well-led as good because:

- The registered manager led the service well and had achieved leadership qualifications to do the job. Staff were aware of the organisational values and were committed to providing care in line with these. The recruitment process had changed so staff had a values based interview.
- There was a positive culture within the house, staff felt respected and valued as members of the team and there was support from the registered manager. There were good working relationships within the team and there was pride in working for the service.
- Staff received supervision and appraisals in line with the service policy. Staff were aware of the whistleblowing policy and said that felt they could use it without fear of victimisation.
- Policies were in place to guide staff within their work. Managers and staff conducted audits of notes within the house and in other houses in the organisation. Staff monitored outcomes and effectiveness of client treatments.
- The service maintained and discussed the organisational risk register at the business meeting and agreed to escalate risks to senior management and board level if needed. The service had emergency procedures in place to mitigate potential obstacles to business continuity.
- Records were stored safely and staff felt they had the necessary tools to do the job both on paper and electronically on the computer.

Summary of this inspection

- Clients had regular opportunities to give feedback about the service, including; house meetings, evaluation forms, suggestion box and a feedback book. A “you said, we did” board was kept up to date to demonstrate changes made.

However:

- The service did not have thorough governance systems in place to ensure good oversight and risk management of incidents and safeguarding. Managers therefore did not monitor to look for trends, this meant that if the same incident kept on occurring then there was no oversight to look at the reasons why or for example, if there was a gap in staff training.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had completed training in the Mental Capacity Act and had a good level of understanding of the Mental Capacity Act and the guiding principles.

The service had a policy on the Mental Capacity Act including Deprivation of Liberty Safeguards that staff could refer to.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Substance misuse services	Requires improvement	Good	☆ Outstanding	Good	Good	Good
Overall	Requires improvement	Good	☆ Outstanding	Good	Good	Good

Good

Substance misuse services

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

Are substance misuse services safe?

Requires improvement

Safe and clean environment

- Francis House was visibly clean and there were arrangements in place to ensure the service was kept clean and tidy. Clients staying at the service were support by staff and peers to clean and tidy the communal areas of the house as well as their own bedrooms. This meant that clients learned valuable skills that they could take with them when they completed treatment. These were called 'therapeutic duties' and were required to be completed daily. Staff assisted with the cleaning and did daily checks to ensure that therapeutic duties had been completed. There was a weekly deep clean of the house and a manager walk round to ensure that standards were high. The house was well maintained but in the process of being redecorated.
- Clients had a bedroom and most of the rooms were en-suite. Staff admitted a client into a shared bedroom if they were having an assisted withdrawal. An assisted withdrawal is a period where a client is prescribed medication to help them safely withdraw from a substance. Staff moved clients into single rooms as their treatment progressed.
- The manager completed environment health and safety checks, this included an assessment of ligature points. A ligature point is anything which could be used to attach a cord, rope or other material for hanging or strangulation. Steps had been taken following the audit, such as locking bedrooms that were not being used, to ensure the safety of the environment. Staff walked round the house daily to check the safety of the environment, for example that cords were safely tucked away and windows and lights were working.
- Staff adhered to infection control principles such as hand washing and disposing of clinical waste. Hand washing signs were clearly displayed around the service and there were hand gel signs prompting people to clean their hands when they entered the building. There was no hand washing sink available in the clinic room. However, antibacterial gels and wipes were available and hand washing sinks were available in other parts of the building.
- There was an automated external defibrillator (AED) within the building. An AED is a lightweight, battery-operated, portable device that checks the heart's rhythm and sends a shock to the heart to restore a normal rhythm. At the previous inspection in February 2016 there was no AED at Francis House so we advised the service that they should get one. Both staff and clients had been trained in using the AED.
- The service had a de-choking device in the dining room, for use when debris cannot be removed by usual methods. The service had also purchased ventilated pillows for client's bedrooms who were at risk of a seizure or for use if a client had a seizure face down to prevent suffocation and head injuries.
- The service had trained the residents in fire safety to ensure that they understood fire procedures and the risks of smoking inside the house. The manager completed regular fire safety checks and practiced evacuation procedures.

Safe staffing

- Staffing levels were safe and there were plans in place to cover vacancies, sickness and annual leave. The service

had two vacancies at the time of the inspection, one for a counsellor and one for a registered manager. The registered manager at the time of the inspection had advertised to fill these posts. Bank staff were being used to cover for the counsellor post. However, due to the low client numbers at the house there was no urgent need to fill the counsellor post. We heard that there was difficulty in filling the vacant registered managers post due to the lack of suitable candidates applying. There was no use of agency staff as they had their own bank staff to cover shortfalls in staffing. The manager of the service felt that it was not guaranteed that agency staff would share their approach and ethos of recovery.

- The service had a low sickness and turnover rate. There was a 1.6% staff sickness rate in the previous 12 months up until 12 November 2018. Two substantive staff had left in the same period.
- Volunteers and recovery champions were part of the team. Recovery champions were volunteers who were in recovery from addiction that staff encouraged to support and mentor clients. All staff demonstrated a very high level of knowledge and skill in safety around the management of alcohol and substance misuse.
- Staff were up-to-date with their mandatory training. Mandatory training included Mental Capacity Act, safeguarding adults and children, infection control and addictions training which included withdrawal from alcohol and drugs. When staff needed to renew their mandatory training, there were dates booked in.

Assessing and managing risk to clients and staff

- Staff did not complete comprehensive risk assessments for clients admitted to the service and there was no evidence of crisis planning. We reviewed five care records for clients at Francis House and there was a lack of detail to inform staff of risks. The templates used were generic which meant that a client's name was added to a pre-populated template that was the same for every client. The templates used were dependent on whether staff ticked the risk in the initial assessment. For example, if a client had a history of suicidal thoughts or self-harm then the corresponding risk assessment/ highlighted need template was used. Staff told us that they kept a lot of client information in their heads.
- We discussed the use of the templates with staff who said that the assessment acted as a disclaimer for clients to sign to say they would not self-harm and would adhere to the therapeutic agreement. The templates did not provide detail around the highlighted risk, therefore there was little information documented to inform staff of the potential current or historical risks. However, staff demonstrated that they were aware of clients risks and their treatment when we spoke with them.
- Staff responded safely to a deterioration in client's health or behavioural change. Staff explained how they responded to changes in mental health and behaviour, for example, by using their observation policy to increase support from staff or to do 'walking therapy' where they went for a walk locally while they talked. We heard that there was a good relationship with the local GP and with community mental health teams, staff used A&E when needed for both physical health problems and mental health deterioration they could not manage in house.
- The service provided clients with a clear list of banned items to keep the house safe, for example substances.
- The care records held plans for unexpected exit from treatment plans and staff described how they supported clients who wanted to leave. Care records showed that there was prior agreement of where a client would go if they left treatment early. The service had a policy of not discharging immediately, for example, if they were intoxicated, so instead put clients up in a bed and breakfast at the expense of the service. Staff said that they tried their best to stop clients leaving the service early if there was a risk of relapse.
- Despite the service reviewing blanket restrictions there were still a number that remained in place. The service had reviewed access to items such as condoms as they had previously been banned and had resulted in clients breaking house rules for possessing them. Access to these was a decision made by the team to minimise the risk of pregnancy, blood borne viruses and sexual transmitted diseases amongst the clients. WIFI had been opened for all clients to access. However, access to mobile phones had been reviewed so they were allowed on the secondary stage of treatment but they continued to have access restricted on the primary stage. We also heard that staff prohibited phone calls in private during their first week of treatment. Staff did not review restrictions according to the stage of treatment on an individual basis, however, the length of the stage of treatment was negotiated according to the progression of the client.

Good

Substance misuse services

Safeguarding

- Staff had good knowledge of safeguarding procedures that helped them protect vulnerable adults from abuse. Staff received training in safeguarding and appointed a safeguarding staff member each day to respond to any safeguarding concerns. When a client was further on in their treatment, staff approached them to have safeguarding responsibilities so that if they became aware of an incident then they could bring that concern to staff to deal with. The safeguarding policy stated that if staff identified a safeguarding concern, they should tell a manager who would make the referral. However, staff demonstrated knowledge of how to raise a safeguarding alert and stated that they would do so if a manager was not available. Francis House had good a relationship with the local authority.

Staff access to essential information

- Staff used paper records to store essential information related to the care of clients staying at the service. These were kept in a folder and stored safely in a lockable cabinet.

Medicines management

- Medicines were not always prescribed safely due to staff not using medicines reconciliation processes as routine. Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. We reviewed all medicine record charts in the house and spoke to staff who dispensed and managed medicines.
- Support workers transcribed medicines from the boxes that clients brought in with them on admission, there was no standard double checking of the charts or routine contact with the clients GP to ensure that medicines brought in were ones that had been prescribed. This meant that staff risked writing a prescription chart for a medicine that was not prescribed by the clients GP. National Institute for Health and Care Excellence (NICE) guidance on medicines optimisation recommends clear communication around medicines within 24 hours of a client moving from one care setting to another in order to have a complete and accurate list of prescribed medicines to maintain safety.
- Clients accessing the service to have an assisted withdrawal received assessment and a reducing regime of medication to help them safely withdraw from drugs or alcohol. There was a dedicated doctor in charge of the assessment and prescribing of medication for assisted withdrawal. Care records clearly showed the doctors assessment prior to detox commencing.
- All medicines kept in the cabinet were in date. Staff had accurately checked and completed the controlled drugs register. Emergency medicine to be administered in the event of an opiate overdose was present and in date. Staff audited medicines daily and the manager audited medicines on a weekly basis to count tablets and check for omissions. Francis House received audits from the external pharmacist annually. Staff recorded fridge and room temperatures to ensure that medicines were stored at a safe temperature.
- Clients progressed onto self-medication regimes to help them manage their own prescribed physical and mental health medication. This was risk assessed prior to starting to ensure that the client was appropriate for the step.

Track record on safety

- Francis house reported five serious incidents in the 12 months leading up to the inspection. These included clients being taken to hospital, and an incident that was reported to the police.

Reporting incidents and learning from when things go wrong

- Staff knew what to report as incidents and how to report incidents. Staff reported incidents on a paper record and met together to discuss and learn from incidents. Staff described a supportive team around incidents and that they felt confident in managing incidents such as rule breaking or violence and aggression. The manager held a record of all incidents that occurred in the house, however it was not clear if learning from incidents was cascaded to the wider team, for example if a staff member was not at work to have the de-brief and immediate learning.

- Managers demonstrated that they were aware of the duty of candour in relation to incidents. The duty of candour puts responsibility on the service to be honest when things go wrong.

Are substance misuse services effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff ensured that there were plans of care in place however they were completed on generic templates. We looked at five care records including recovery and medical care plans. The care plans were holistic, however not personalised. The templates were generic with fields where clients` names could be added rather than creating a care plan that reflected the individual. This meant that all clients had the same care plans in place despite having very different presentations. The medical care plans described detoxification regimes, actions to take in an emergency and monitoring of withdrawal symptoms.
- Physical health care plans were in place and were comprehensive and detailed. Staff took clients' physical health needs into consideration. We saw examples of physical health issues that had been planned for and were being monitored.

Best practice in treatment and care

- The service followed national best practice guidelines treatment such as National Institute for Health and Care Excellence guidelines (NICE). Staff we spoke with told us they used the Department of Health drug misuse and dependence UK guidelines on clinical management (also known as the 'Orange Book'). The registered manager told us that two hard copies of the Orange Book were available for staff to refer to on site.
- The service used the '12-step' model to support clients who were on detoxification treatment. The 12-step model is focused on interaction within a group support structure as opposed to individual counselling and medical intervention. Whilst counselling and medical intervention were also part of addiction recovery, it was the 12 steps model that participants go through that provided a bridge between past behaviours and an addiction-free future.
- The provider submitted data to the National Drug Treatment Monitoring System (NDTMS) as a means of monitoring the effectiveness of the therapeutic program. Staff evaluated the effectiveness of treatment and clients` progress by using an in-house tool called entry and exit questionnaire. These were reviewed to inform improvements.
- Staff used the clinical institute withdrawal assessment of alcohol scale (CIWA-Ar) and clinical opiate withdrawal scale (COWS) to identify and monitor withdrawal symptoms. Staff were aware and able to identify withdrawal symptoms by observations and when reported by clients. Staff acted promptly by monitoring and seeking medical advice if required. The GP did not routinely prescribe PRN for detoxification regimes but would provide verbal prescriptions over the telephone if extra doses were required. Staff described good practice around receiving verbal prescriptions. However, staff did not always clearly document communication with the GP.
- The service provided individual psychological therapy to clients. Staff offered daily groups based on cognitive behavioural therapy principles.
- Staff ran therapeutic groups five days per week for around an hour. We attended one of these groups and staff used cognitive behavioural therapy techniques which was appropriate for use with this client group. Clients appreciated the therapeutic groups as they said the groups addressed their needs and helped them in their recovery journey.
- Records showed staff enabled clients to access the physical healthcare they needed including dentists, GPs, hospital appointments and other specialists such as physiotherapists. The service also weighed clients weekly if they were concerned about weight loss.
- The service catered for clients who had specific dietary requirements. For example, one client was on a low sugar diabetic diet plan and staff were providing a diet plan to support the client.
- The service employed a private psychiatrist to assess and work with clients who had symptoms of mental health illnesses in circumstances when they could not access local mental health services.

- Psychoactive medications are used to treat a variety of mental health conditions. Although Francis House followed a 12-step treatment model, which traditionally does not support medical treatment of mental health problems, this facility enabled clients to access support for their mental health problems should this deteriorate whilst being at Francis House.
- Staff were signposting clients to a local service that issued take home naloxone. This is an essential injectable medication that can reverse opiate overdose.

Skilled staff to deliver care

- The multi-disciplinary team comprised of counsellors, support workers, a registered manager and team leaders.
- There were professionally qualified staff working in the service such as counsellors. The support workers had relevant qualifications and training for their role.
- Staff received specialist training in approaches that were recommended for substance misuse rehabilitation providers, such as, cognitive behavioural therapy, relapse prevention, harm reduction and motivational interviewing.
- The provider trained staff in the treatment model and issued a copy of the treatment model book.
- Staff had access to regular supervision and annual appraisals. Staff supervision were conducted every two months using a standard form and were delivered by an external supervisor. Staff were involved in their appraisals. In staff records we reviewed, staff had personal development plans. All staff had had an appraisal within the past 12 months completed an induction program at the start of employment.

Multi-disciplinary and inter-agency team work

- There was a multi-disciplinary team meeting every week with individual clients reviewed every week. The support workers and counsellor team attended the meeting. Staff always invited the clients care manager for clients who were from other areas and counties but they were not always able to attend.
- Clients records showed good joint working between the support workers and counsellor teams. Staff attended these team meetings weekly.
- Staff completed a handover at the beginning and end of each shift. An additional handover took place in the morning where the counsellors and nursing staff handed over and shared information. Staff had daily process meetings where they reflected on the day and put in place any necessary changes to the program or client's individual treatment.
- Managers told us they had effective working relationships with other organisations such as social services and a local GP practice.

Good practice in applying the MCA

- All staff had completed training in the Mental Capacity Act and had a good level of understanding of the Mental Capacity Act and the guiding principles.
- The service had a policy on the Mental Capacity Act including Deprivation of Liberty Safeguards that staff could refer to.

Are substance misuse services caring?

Outstanding ☆

Kindness, dignity respect and support

- The service had a strong recovery ethos with staff devoted to ensuring that clients had excellent outcomes. The service put clients at the heart of the service and staff consistently stated that they were there to support them and help them change their lives. Clients said that the staff were committed to helping them turn their lives around and that they saved their lives. We heard that all clients were grateful for the opportunity to be supported by the staff at the house and be treated like a family. They were consistent in saying Francis House was amazing and that decisions and support came from a caring place, staff were always nice and encouraging.
- Staff demonstrated an outstanding attitude of respectful, compassionate care. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted clients' dignity. Relationships between people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
- The provider ensured that the needs of clients were met. Bursary beds were routinely offered to clients in crisis, clients who needed to remain in treatment longer

or who did not have accommodation to return to when treatment had finished. The ethos of the organisation was to ensure that all vulnerable clients were cared for, irrespective of the funding received.

- Clients praised the staff in helping them open-up and talk about areas of their life they had previously kept to themselves. Staff taught them to be truthful and honest as well as to take care of themselves physically and emotionally. Clients felt respected by staff and they understood changes of emotion such as getting angry and wanting to leave. We heard of several stories where the service had gone over and above helping clients, such as those physically unwell and with nowhere to go. Free therapy and placements were given as there was a policy of not throwing anyone out on the street. There were adaptations to normal therapy such as doing walking therapy to help get the best out of the clients.
- Through assessing clients appropriately, and working with them collaboratively, staff knew how to meet their needs and they ensured that clients had access to other teams when they needed it.
- Clients could have open discussions about their personal, cultural, social and religious needs with staff, as they knew staff would respect their wishes and help meet their needs. We saw that staff had taken steps to help a client to stay engaged with their local religious community. We saw that staff had taken steps to help a client to stay engaged with their local religious community for example staff supported clients to attend the mosque in Southampton area. Staff also told us that the established good relationship with the local Jewish community which supplied the house with specific meat products when required. Staff were keen to promote a culture of respect and assured clients that they were safe to raise any allegations of discriminatory behaviour.

The involvement of people in the care they receive

- Clients participated in a football competition called the Unity Cup set up by the company and invited local recovery services to join and bring a team. The manager stated Francis House normally won. There was a volley ball tournament and barbecue in the summer and they put on a reunion where they invited over 300 ex-residents to an open evening at the hotel. Ex-residents shared their experience and their recovery. The service had also put on a gala to raise money to pay for clients that had no funding but needed treatment, we found that a lot of free treatment was given away.
- Throughout the admission process, staff helped clients settle into the house. The service had a detailed welcome pack and assigned staff to be key workers with clients in the house.
- Clients were involved in decisions about the services they used. Staff involved them as panel members when they held interviews for new staff. Clients and carers had been included in discussions about the house developments.
- Staff routinely collected feedback from clients in a way they could understand. This feedback was collated and helped staff to address anything that arose. The House Group Leader book allowed clients to communicate any requests with staff, for example going to the doctors or to the shops.
- Staff collected formal client feedback quarterly and on discharge and held weekly house meetings for clients to raise any issues. Clients told us that staff always responded to issues raised and explained the reasons for decisions made.
- Staff ensured that clients had access to advocacy and included the advocate in meetings as appropriate. This was important to help ensure clients had their voice heard.
- Carers we spoke with said staff were very supportive. They felt they were involved in their relatives' care, and that staff could support them as well when they needed it.
- Carers were helped to access carers assessments to ensure that their needs were assessed and met.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- There was no waiting list for the service. The service admitted urgent referrals, in some instances, in under 48 hours.
- Staff screened and assessed referrals for suitability. The admissions manager assessed clients and discussed with the manager before agreeing admission. There were no documented exclusion criteria as staff agreed admissions on an individual basis.

- The service employed a driver who collected clients from anywhere in the country and drove them to the service to facilitate admission.
- In the event of clients relapsing, staff tried to work around triggers for relapse or supported them to transfer to another service rather than discharging them. Discharging clients immediately following relapse is often normal practice within many substance misuse services. The service transferred clients to other houses within their organisation if they could not meet the client's needs. The service also supported clients to access treatment and accommodation outside of the organisation.
- The service offered supported living which clients could move onto after successful completion of treatment if they wanted to stay in the area.
- The service provided aftercare to support clients with their recovery journey following discharge. Clients accessed 10 days of treatment in the house following discharge to facilitate the transition from treatment back into the community. The clients also had access to lifelong aftercare through the service's supported housing provision.
- Staff did not document discharge plans. None of the client care records we reviewed contained a discharge plan. However, staff discussed good practice around planned and unplanned discharges and transferring clients to other services.

The facilities promote recovery, comfort, dignity and confidentiality

- The service had a range of rooms for clients, including living rooms, a large dining room and a multi-faith room. There were other rooms for group and individual therapy. The living rooms were bright, spacious and well maintained.
- Bedrooms were individual and shared rooms with an en-suite bathroom. Clients undergoing a medical detoxification slept in a shared bedroom with a client further along in their treatment to provide night time support and alert staff if there was a problem. All other clients had their own bedrooms.
- Clients had private spaces to make telephone calls from. There was a payphone in a private location and some clients used their mobile telephones in their bedrooms. However, clients in their first week of treatment were expected to make all telephone calls in the office in the presence of staff.

Clients' engagement with the wider community

- Staff supported clients to access and attend external support groups such as Alcoholics Anonymous and Narcotics Anonymous.
- Clients had limited access to the community within the first phase of treatment. They were required to take a volunteer with them when accessing the community. However, specific requests were considered by staff and planned for with the clients and access to the community was more flexible in the second phase of treatment.
- Staff supported clients to access suitable voluntary work and education opportunities.
- The service organised day trips for all the clients. For example, trips, ice skating or for a walk in the countryside.

Meeting the needs of all people who use the service

- The ground floor was wheelchair accessible. There were bedrooms and bathrooms on the ground floor. However, there were no mobility aids in the bedrooms or bathrooms requiring clients to be able to transfer independently.
- When clients had additional care needs, such as personal care, the service used a domiciliary care agency to provide this support to enable the client to remain in treatment.
- Staff provided access to spiritual support on and off site. Clients accessed faith groups in the community and had a multi-faith room on site.
- Staff understood the clients' needs, encompassing their different social and cultural needs including those with protected characteristics such people from the lesbian, gay, bisexual and transgender community.

Listening to and learning from concerns and complaints

- Francis House had not had any complaints in the 12 months prior to our inspection. However, staff and clients both knew the complaints procedure. Staff escalated complaints to their manager. Serious complaints were referred to the board of directors for investigation and response. Other complaints were dealt with by the manager.
- Staff gave clients information on the complaints procedure on admission. Information was available in

their induction packs. Staff regularly informed clients of the complaints procedure in house meetings. Clients could also raise concerns informally through a feedback book, house meetings and in client evaluation surveys.

Are substance misuse services well-led?

Good

Leadership

- The registered manager led the service well and had achieved leadership qualifications to do the job. The chief executive was supportive of the registered manager and there was clear clinical leadership. Managers were visible in the service and led from the front and by example. The registered manager for Francis House said that they would not ask a staff member to do something that they were not prepared to do themselves. Therefore, they were involved in providing front line care when needed and got involved in therapeutic duties to support clients and staff.

Vision and strategy

- Management and staff shared a clear definition of recovery that was embedded throughout the service. Managers and staff were committed to putting clients first. This was evident in the way that staff spoke about the clients and in interactions we observed between staff and clients.
- Staff were aware of the organisational values and were committed to providing care in line with these. The recruitment process had changed so staff had a values based interview. The ethos of the service was to go the extra mile for clients and this was evident in the way the registered manager and the staff spoke and conducted themselves. We heard that they put people before profits and had provided free care to clients who were not ready to end treatment but had their funding stopped. The manager supported staff to try and keep clients in treatment. They spent time with the team to get them to understand clients' problems, to make sure that they were signed up to helping them and not discharging clients when this could be avoided.
- The service was committed to ensuring money was available where it was most needed, for example in providing clients with healthy food choices over decorative issues with the house that could wait to be corrected.
- Staff had been included in decisions for the service and had been recruited due to their commitment to clients' recovery.

Culture

- There was a positive culture within the house, staff felt respected and valued as members of the team and there was support from the registered manager. Morale had been low in recent times but the service had made positive changes to the management to help increase morale and support.
- Staff had good working relationships within the team and there was pride in working for the service. We were told that although here were pressures to perform, staff were not overwhelmed by the workload and that there was not too much stress.
- Staff received supervision and appraisals in line with the service policy, this included conversations about training and career development as well as current practice. Staff told us that supervision was of a good quality and effective and that managers supported them to access training.
- Staff were aware of the whistleblowing policy and the manager said that in the past they have had to encourage to staff to use it. There was a positive culture around openness and team support, therefore there had been no bullying or harassment cases. The manager felt that any issues amongst staff or clients and staff were dealt with quickly and at the time.
- The registered manager told us that they dealt with poor performance when needed. We saw personal development plans and action plans in staff supervision and appraisal records.

Governance

- Policies were in place to guide staff within their work. Some of these had been created from previous learning within the organisation, for example, the policy of referring a client to the local mental health service prior to admission if they had mental health support in their home town. A steering committee was in place to raise issues and incidents from the house to share across the organisation.

- The service did not have sufficient governance systems in place to ensure sufficient oversight and risk management. There was no oversight of trends of incidents by the manager of the house. Staff provided the management with an incident form to be stored in one place. However, there was no analysis of incidents over a period to look for trends, this meant that if the same incident kept on occurring then there was no oversight to look at the reasons why or for example, if there was a gap in staff training.
- The manager did not log safeguarding referrals or monitor their progression. This meant that there was no internal oversight of safeguarding alerts made to ensure that the necessary steps had been made to protect vulnerable adults.
- Managers and staff conducted audits of notes within the house and in other houses in the organisation. This allowed practice to be reviewed and any shortfalls to be picked up.
- Managers evaluated the effectiveness of client treatment. Clients completed feedback questionnaires every quarter and on discharge. Treatment outcome profiles (TOPS) were completed and submitted to National Drug Treatment Monitoring System (NDTMS). However, the latest information available to manager was almost a year old. The service also gauged the effectiveness of the service through contacts they received from previous clients such as phone calls and Christmas cards.

Management of risk, issues and performance

- The registered manager maintained a service health and safety risk assessment that included environmental risks and necessary actions.
- The service maintained and discussed the organisational risk register at the business meeting and agreed to escalate risks to senior management and board level if needed. We saw evidence of this in the minutes of these meetings.
- The service had emergency procedures in place to mitigate potential obstacles to business continuity such as loss of amenities, infection control and adverse weather. The plan did not cover what the provider would do if all the staff were sick at the same time. When staff were on leave, other staff covered for them as extra bank shifts and there were no agency staffing arrangements.
- Managers monitored staff performance within their teams. Performance management plans were in place where they were needed.

Information management

- Staff stored the paper records in a way that maintained client confidentiality.
- Staff had access to relevant policies which were accessed via the computer on the intranet. There were enough computers and staff told us that they had access to equipment to help them provide care to clients.
- The manager discussed learning from individual incidents and complaints with staff via emails, in team meetings, during supervision or to individual staff.

Engagement

- Staff told us feedback from clients was collected through satisfaction surveys. However, at the time of our inspection no feedback had been received to evidence this.
- The manager maintained a “you said, we did” board with examples of feedback received and the actions taken by the service.
- Clients had regular opportunities to give feedback about the service, including; house meetings, evaluation forms, suggestion box and a feedback book. The service also gauged client’s opinion of the service through self-evaluation forms during and on completion of treatment.

Learning, continuous improvement and innovation

- The registered manager helped clients get involved with digital addiction research at the local university.

Outstanding practice and areas for improvement

Outstanding practice

- The provider actively worked to reduce barriers to treatment for their clients. For example, the service had admitted clients with their pets, purchased support from domiciliary care agencies for clients requiring personal care and employed a driver who collected clients when public transport was a barrier to treatment.
- The ethos of the service was to go the extra mile for clients and put people before profits. The provider regularly provided free care to clients who had unmet needs but did not have funding available. The provider offered free aftercare for life to all clients after completion of treatment.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff follow safe medicines prescribing and management procedures. (Reg 12)
- The provider must ensure that risk assessments reflect all risks for clients using the service. (Reg 12)

Action the provider SHOULD take to improve

- The provider should ensure that restrictions are individually assessed.
- The provider should ensure that there are effective care plans in place that are personalised.
- The provider should ensure that managers have robust oversight of incidents and safeguarding procedures.

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 Clients care records did not contain sufficient information around risks or their management. Risk assessments highlighted if a risk existed but did not provide detail around the highlighted risk, therefore there was little information documented to inform staff of the potential current or historical risks. Staff did not document crisis planning with clients. This meant there was no documented plan in place for staff if a client's mental health deteriorated. Staff did not routinely obtain GP summaries prior to starting detoxification regimes. Staff did not clearly document medical decisions, instructions or conversations with medical professionals. There was no process in place to ensure that client's medication was checked against the most up to date and accurate list of prescribed medication. Community staff sent a GP summary, including a medication list, up to four weeks prior to admission. Clients brought in 28 days of medication with them and this was checked against the potentially inaccurate GP summary. Support workers transcribed medicines onto drug charts on a client's admission. There was no standard double checking of these charts by another member of staff or a prescriber. This was a breach of regulation 12(2)(a)(b)(g)

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Requirement notices