

Shardale Specialised Therapeutic Community

Quality Report

Woolfield House
Wash Lane,
Bury,
BL96BJ
Tel: 0161 764 3991
Website: www.shardales.co.uk

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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

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.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- There service was clean and well maintained. Maintenance records were up to date and comprehensively completed. There were good health and safety arrangements in place regarding cleaning and kitchen use. Staffing levels were adequate for the service with no use of bank or agency staff. Staff understood their responsibilities in terms of safeguarding. Staff completed thorough risk assessments. Medicines were managed safely including self-medication.
- Staff completed comprehensive needs assessments for clients and staff and clients developed recovery based, outcome focussed care plans. The treatment programme evidenced good practice guidance. Staff completed audits to check clinical care and the service

Summary of findings

supplied required information to the national drug treatment monitoring service. Managerial and clinical supervision took place regularly and all staff received an annual appraisal.

- Staff respected clients and valued them as individuals. Feedback from clients was positive about the way staff treated them. There was a strong, visible client-centred culture. All clients had full involvement with their treatment throughout their stay. Carers gave positive feedback on the service and the staff.
- Admissions were planned with clients able to visit the service and spend time there prior to admission. Discharge planning began at admission and a clear plan and outcomes were devised to work within the timescale set. Staff worked with clients to prevent unplanned discharges.

- There was good provision of rooms and space for therapy. The treatment programme provided activities for clients seven days a week. The rehabilitation programme included free time and dedicated time for clients to spend with their key worker.
- There was a good governance structure to oversee the operation of the service. There were clinical governance plans in place with regular review and audit.

However, we also found the following issues that the service provider needs to improve:

- The service currently has no registered manager.
- Staff were not up to date with all mandatory training.
- Staff did not have any further training provided in terms of substance misuse or therapeutic approaches or training in running group work programmes.
- Staff do not receive training in understanding the Mental Capacity Act.
- There was no Mental Capacity Act policy.
- There was no Duty of Candour policy.

Summary of findings

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Shardale specialised therapeutic community

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Summary of this inspection

Background to Shardale Specialised Therapeutic Community

Shardale specialised therapeutic community is an independent substance misuse service that is part of the Shardale Group. The Shardale group has two locations offering structured rehabilitation programmes, one in Bury and the other in St Anne's. There is also a structured day programme run in Preston.

This service is situated in Bury, in a residential area close to public transport and local amenities. Shardale specialised therapeutic community offers a personalised treatment programme for up to 29 men and women, enabling them to make informed treatment choices that support their individual recovery journeys. There were 9 people resident on the day we inspected the service as there were building works being undertaken to reduce the overall number of bedrooms to make all rooms en suite.

Clients were funded through local commissioning arrangements. The service accepted clients who had completed inpatient detoxification programmes, primarily alcohol detoxification, and required ongoing rehabilitation. Referrals were made by community

keyworkers, primarily community alcohol team keyworkers or commissioners of substance use services. Keyworkers remain involved during the treatment process and attend regular reviews.

The average length of stay was approximately six to nine months.

Shardale specialised therapeutic community was registered to provide the following regulated activities:

Accommodation for persons who require treatment for substance misuse.

There was a nominated individual and an application was in process for a new registered manager. In the meantime, a senior manager from within the organisation was supporting the team manager in undertaking the registered manager responsibilities.

The Care Quality Commission had previously inspected the service in July 2013 and the service was meeting all required standards at that time.

Our inspection team

The team that inspected the service comprised CQC inspector Andrea Tipping (inspection lead) and two other CQC inspectors.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

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

Summary of this inspection

- Is it well led?

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

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the physical environment, and observed how staff were caring for clients who used the service
- spoke with two clients who were using the service
- reviewed written discharge feedback left by previous clients
- reviewed written feedback from 30 carers, friends and family over a 12 month period
- spoke with the nominated individual and the team manager
- spoke with one member of staff and one volunteer
- attended and observed a daily meeting for clients who used the service
- looked at five care and treatment records for clients who used the service
- reviewed medicines management arrangements, all medicines administration records and medication stocks for clients using the service
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We were able to review feedback from carers and relatives over the last 12 months, which was positive in terms of the service and individual staff members.

Feedback questionnaires were completed by clients as they left treatment and these were positive about the service.

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 do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service was clean and well maintained.
- There were good health and safety arrangements in place regarding cleaning and kitchen use.
- All staff had attended fire safety training and there were regular fire drills.
- Maintenance records were up to date and comprehensively completed.
- Staffing levels were adequate for the service with no use of bank or agency staff.
- Risk assessments were thorough and reviewed regularly.
- Medicines were managed safely including self-medication.
- All staff were aware of safeguarding and knew how to raise concerns.
- There had been no serious incidents in the previous 12 months.

However, we also found the following issues that the service provider needs to improve:

- The service currently has no registered manager.
- Staff were not up to date with all mandatory training.
- There was no policy outlining Duty of Candour.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff completed comprehensive needs assessments for clients.
- Staff and clients developed recovery based, outcome focussed care plans.
- Physical healthcare needs were addressed in liaison with a local GP service.
- The treatment programme evidenced good practice guidance.
- Staff completed audits to check clinical care.
- The service supplied required information to the national drug treatment monitoring service.
- Staff were supported to complete additional health and social care training.
- Managerial and clinical supervision took place regularly.
- All staff received an annual appraisal.
- Staff maintained links with commissioners.

Summary of this inspection

- Clients were supported to access community organisations and volunteering opportunities.

However, we also found the following issues that the service provider needs to improve:

- Staff did not have any further training provided in terms of substance misuse or therapeutic approaches or training in running group work programmes.
- Staff did not receive training in understanding the Mental Capacity Act.
- There was no Mental Capacity Act policy.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff respected clients and valued them as individuals.
- Feedback from clients was positive about the way staff treated them.
- There was a strong, visible client-centred culture.
- All clients had full involvement with their treatment throughout their stay.
- Clients who told us they were fully involved in developing care plans and planning outcomes.
- Clients were encouraged to feedback about the service and understood the complaints procedure.
- Carers gave positive feedback on the service and the staff.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Admissions were planned with clients able to visit the service and spend time there prior to admission.
- Discharge planning began at admission and a clear plan and outcomes were devised to work within the timescale set.
- Staff worked with clients to prevent unplanned discharges.
- There was good provision of rooms and space for therapy.
- The treatment programme provided activities for clients seven days a week.
- The rehabilitation programme included free time and dedicated time for clients to spend with their key worker.
- Client's cultural and religious needs were identified through assessment.
- Adjustments were made according to need and agreed at the pre-admission assessment, for example, mobility issues.

Summary of this inspection

- There was a complaints and concerns book to capture both verbal and written complaints.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service had clear visions and values.
- There was a good governance structure to oversee the operation of the service.
- There were clinical governance plans in place with regular review and audit.
- Staff received appropriate appraisal and supervision.
- Personnel files were well maintained.
- Staff felt there was good morale and support within the service.
- There was a commitment to gathering feedback and improving the service.

However, we also found the following issues that the service provider needs to improve:

- The service manager and nominated individual were aware that staff training was not up to date

There were no policies in place for Mental Capacity Act or Duty of Candour.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Clients required capacity in order to fully engage with the treatment programme. All clients were assumed to have capacity and staff told us they would refer to the local authority and request a capacity assessment if they thought this was required.

Mental Capacity Act training was not part of the service mandatory training and there was no Mental Capacity Act policy in place to offer guidance to staff.

We were able to discuss a situation where a client was felt to have fluctuating capacity, possibly because of physical health concerns. Although this was being addressed by the GP and staff in terms of physical health care and investigations, there had not been a capacity assessment undertaken. This meant that the clients understanding of his current care and treatment had not been assessed.

Substance misuse services

Safe

Effective

Caring

Responsive

Well-led

Are substance misuse services safe?

Safe and clean environment

The service was set within a large, three storey building set back from the road. There were close circuit television cameras monitoring the entrance and the car park to ensure the safety of staff and clients. The atmosphere was welcoming and clients told us they felt safe. Visitors were asked to sign in and out. One member of the community in the house acted as a gatekeeper each week. This meant that one person took sole responsibility for answering the door, which helped ensure the safety of everyone in the house.

The environment was clean and well maintained. Clients cleaned the house according to a rota. Cleaning products were locked away when not being used and staff completed a checklist of essential cleaning tasks each day. Items used for cooking and cleaning, such as knives, chopping boards, mops and buckets, were colour coded to aid effective infection control. Clients cooked for the house and followed a safe food routine including basic training on food hygiene shortly after admission. Fridge temperatures were recorded daily and different foods were stored appropriately. Posters such as knife safety and common causes of accidents were displayed on the kitchen walls.

Staff allocated bedrooms according to gender. Females stayed on one corridor and males on another. Bathrooms were available on each of the corridors. All bedrooms had lockable doors. Bedroom corridors had close circuit television cameras installed to ensure the safety of clients. This was not continuously monitored and was discussed with clients when they were admitted. The provider was in the process of adapting the location so that there would be single en-suite bedrooms. Staff carried out room checks at 9 am to ensure clients kept their rooms clean and tidy.

All staff had undergone fire safety training. This meant there was always a fire warden on the premises. We saw evidence of fire evacuation drills. Fire extinguishers had been tested. There was a current gas safety certificate. All portable electrical appliances were tested every year.

Maintenance records showed a regular programme of ongoing maintenance and these were used to record when urgent maintenance had been needed and completed.

Safe staffing

The staffing establishment comprised six permanent staff and two volunteers. The nominated individual and a trainee manager also worked within the service. The staff and volunteers acted as keyworkers and group facilitators. Keyworkers engaged with a maximum of five clients. Groups usually consisted of six to eight clients, with the exception of one group that the whole community attended.

The registered manager position at the time of inspection was vacant. The nominated individual was attending to the delivery of the regulated activity and an application was being made for the new team manager to be registered.

There were no other staff vacancies and there had been no staff sickness in the 12 months before this inspection.

Other staff contracted by the service included an external supervisor who provided clinical supervision to all staff on a monthly basis. An external verifier reviewed audits, provided guidance to the managers and supported them to develop a clinical governance plan. A central management team based in Preston monitored the governance arrangements. A counsellor worked on a sessional basis depending on client's needs.

The provider did not need to use bank or agency staff as all posts were filled and sickness levels were very low. Planned

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leave ensured adequate cover and unexpected leave was managed through the goodwill of the team. Staff and clients told us that groups or activities were never cancelled.

All staff including volunteers were expected to undertake mandatory training and then annual refresher training in moving and handling, equality and diversity, fire safety, first aid including basic life support, safeguarding, medicines administration, health and safety and food hygiene. Training levels were below 75% for moving and handling, equality and diversity, health and safety and food hygiene. When we asked, the nominated individual told us that a new contract was being finalised with an eLearning provider and that they were aware that mandatory training was out of date for some staff.

Assessing and managing risk to people who use the service and staff

We reviewed five client's records. Risks were initially identified during the pre-admission assessment process. The risk assessment covered risks such as self-harm, injecting behaviour and criminal behaviour. Where appropriate, the provider had asked for more information, for example, from the local authority or probation service.

The provider used an outcome measure called clinical outcomes in routine evaluation, which was a self-reporting tool that reflects the client's mood. This was used every week and scores identified changes to individuals' mood levels, which might indicate heightened risk and allow action to be taken to reduce those risks. We saw fully completed and comprehensive progress reports in client's files.

Staff made notes in each client's record three times a day. Their notes reflected client's mood and level of engagement. Risk was discussed at handover meetings twice a day so staff had up to date information.

Some activities had specific risk assessments, such as home leave or self-medication. Staff completed a risk assessment detailing the activity, concerns and the likelihood of the risk occurring. The assessment included actions that either staff or the person would take to reduce the risk.

Clients provided staff with details of where they were going and they signed in and out of the building.

There was a policy that provided guidance for when clients left the service unexpectedly by discharging themselves. The client's care coordinator and next of kin were informed and staff provided details of support groups/organisations and contingency planning wherever possible.

The provider did not prescribe medication. However, staff stored and observed clients dispense their own medication, which had been prescribed by other health professionals. This included medication for physical and mental health issued by GPs. Medications were secured safely in a locked cupboard. Closed circuit television cameras covered the area where medication was dispensed after concerns a number of years ago that medicines had been misappropriated by one of the clients. Medicines administration record sheets were used to record administration. These were all fully completed. At the time of inspection, only two clients had medication stored by staff, two were not prescribed any medication and five clients were self-medicating. Clients had locked storage in their bedrooms for medication and self-medication checks were undertaken weekly by staff. On undertaking stock checks for the two clients whose medication was kept by staff, one medication was not in stock since the previous day but had been ordered and supplied that day by the local chemist. There was a process for medicine reconciliation which was ensuring that medication previously prescribed to clients was identified at admission and prompt action taken to ensure continuation of ongoing treatment. First aid boxes were in place around the service and were regularly checked.

Staff received safeguarding training as part of their induction and mandatory training. There was a safeguarding policy that provided guidance for staff and staff told us that they would immediately report concerns to the manager or nominated individual. The provider had not raised any safeguarding alerts in the previous 12 months.

Track record on safety

In the 12 months before inspection, there had been no serious incidents that required investigation.

Reporting incidents and learning from when things go wrong

Incidents were reported using incident forms. We saw completed forms noting actions taken. Accident forms were

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also completed and both types of forms were reviewed to check for actions needed or themes emerging. Information regarding incidents and lessons learned was disseminated to staff through regular team meetings.

Duty of candour

Staff told us they were open and honest when things went wrong. There was a clear culture of transparency in the service. There was no policy outlining duty of candour to guide staff.

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

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

Staff completed an assessment for each client prior to admission. This allowed staff to ensure that the provider could meet the individuals' needs. The assessment considered physical and mental health, drug use, medication, any previous treatments, housing and benefits. A written evaluation of the assessment was kept in the client's record.

Information gathered during assessment was used to inform care planning.

Care plans were recovery focused. Recovery focused means being focused on helping clients to be in control of their lives and build their resilience so that they can live independently in the community. Staff and clients planned care together following the core values of the treatment programme. They identified individual issues and contained clear goals. This meant that client's progress could be tracked. Care plans were simple, individual and recovery oriented. They identified each client's issues, action to be taken, responsibilities, goals and review dates.

Physical health care concerns were addressed. Clients were registered with a local GP who managed physical health concerns. Clients were supported to attend medical and dental appointments. The service had arrangements in place with the GP practice and the pharmacy which worked well. There were no delays in accessing appointments when needed. The pharmacy kept in regular contact with the service and a specific pharmacist was available for advice if needed.

All care plans were detailed and complete. The five records we looked at were regularly reviewed with the client. It was clear what the clients' goals were and how they would achieve them. Notes of daily activities related to the clients' recovery plans. This meant clients could easily understand how they could progress with their recovery.

Best practice in treatment and care

The service delivered a treatment programme with core values that had been developed in line with the 12-step programme. The 12-step programme was originally developed by the alcoholics anonymous fellowship. It utilised principles of mutual aid and peer support. The National Institute for Health and Care Excellence had produced guidance for services managing clients with substance misuse issues. Guidance recommended that clients have access to mutual aid (self-help) support groups normally based on 12-step principles.

In the first 12 weeks of the programme, there was mandatory attendance at sessions including evening groups. After 12 weeks in the treatment programme, clients could access person centred counselling sessions in addition to group work, if they felt this would be beneficial.

A comprehensive group work programme included identifying patterns of behaviour associated with substance use, developing coping strategies, confidence building and relapse prevention. There was a strong focus on developing practical living skills, for example, setting a daily routine and eating healthily. This helped clients build the skills required to help their ongoing recovery and maintain their independence when they returned to the community. Clients were linked in with other organisations and encouraged to develop their social support including mutual aid and support groups which they may continue after discharge.

Clients completed a significant event form and a feelings journal each day. This enabled them to reflect on the day, looking back at what had happened and what they had learnt from that. Staff were available to discuss any concerns clients may have identified in this process. The forms and journals were used to help structure therapy and counselling sessions.

The provider had a formal audit programme. The staff carried out six-weekly audits of care plans and medication. This included stock checks to ensure medications had not been lost or misplaced. Care plan audits included checking

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that all sections were complete and that appropriate consent had been obtained. Other staff also carried out audits, for example, cleaning and fridge temperatures. Audits included any action that needed to be taken. All the audit documents we saw were complete and up to date. This demonstrated that the service worked to ensure minimum quality standards were in place and that action could be taken in the event that high standards were not being maintained.

The service measured outcomes using the national drug treatment monitoring service. The national drug treatment monitoring service is managed by Public Health England. It collects, collates and analyses information from services involved in drug treatment. All drug treatment agencies provide a basic level of information on their activities each month. Providers are able to access reports and compare performance against the national picture.

The provider also used the clinical outcomes in routine evaluation outcome measure. This was a self-reporting tool which measured how the client has been feeling by scoring a set of statements that cover subjective well-being, problems and symptoms, life functioning, risk and harm.

Skilled staff to deliver care

All of the staff and volunteers had experienced addiction themselves and were in recovery. This helped them to develop relationships with clients because they understood clients' behaviours and anxieties. All support workers had completed or were studying for the diploma in health and social care. The trainee registered manager had completed the national vocational certificate in management at level five.

Staff did not have any further training provided in terms of substance misuse or therapeutic approaches or training in running group work programmes.

All staff received managerial supervision in line with the supervision policy. An external practitioner who was accredited with the British association for counselling and psychotherapy provided group clinical supervision on a monthly basis for all staff. It was noted that this provided assurances and ongoing personal development for those staff engaged in therapeutic approaches and models. Supervision was structured and there was a set agenda. Both the supervisor and supervisee signed notes of the supervision session.

Staff received an annual appraisal and set annual objectives. This enabled managers to identify where improvements were needed. There was a policy that provided guidance on addressing performance. The manager told us that any performance concerns would be addressed during supervision and we saw evidence of this in supervision records.

Multidisciplinary and inter-agency team work

Staff attended a handover meeting before and at the end of each shift. Each client was reviewed and discussed. Staff showed a good knowledge of the clients and worked together to deliver care. Following confidential handover discussions, the community leaders including the client nominated as the safe guarder all came into the meeting separately and advised the team about any issues within the community. This ensured that all staff were aware of relevant information.

Staff remained in contact with referring agencies during each client's treatment and informed them of discharge plans. Clients told us they knew who their local social worker or keyworker was and how they could contact them.

Clients were supported to access community organisations and volunteering opportunities. The provider had strong links with other local recovery communities. These included alcoholics anonymous, narcotics anonymous and a local user forum.

Adherence to the MHA (if relevant)

The provider did not admit clients detained under the Mental Health Act 1983.

Good practice in applying the MCA (if people currently using the service have capacity, do staff know what to do if the situation changes?)

Clients required capacity in order to fully engage with the treatment programme. All clients were assumed to have capacity and staff told us they would refer to the local authority and request a capacity assessment if they thought this was required.

Mental Capacity Act training was not part of the service mandatory training and there was no Mental Capacity Act policy in place to offer guidance to staff.

We were able to discuss a situation where a client was felt to have fluctuating capacity, possibly as a result of physical health concerns. Although this was being addressed by the

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GP and staff in terms of physical health care and investigations, there had not been a capacity assessment undertaken. This meant that the clients understanding of his current care and treatment had not been assessed.

The provider had not made any Deprivation of Liberty safeguards applications.

Are substance misuse services caring?

Kindness, dignity, respect and support

Clients told us that staff respected and valued them as individuals. Feedback from clients was continually positive about the way staff treated them. We saw there was good engagement between staff and clients and staff treated clients with dignity, respect and kindness and the relationships between them were positive. This helped establish a therapeutic relationship. Clients told us they felt supported and said staff cared about them. They described staff as friendly, approachable and helpful. There was a strong, visible person-centred culture. The staff ensured clients' dignity, privacy and confidentiality was always respected.

The involvement of people in the care they receive

Before their admission, clients received information about the programme. This included the programme core values, client's rights and house rules. When clients were admitted, they were allocated a "buddy" who introduced them to other clients, showed them around the building and explained the house rules.

All clients had full involvement with their treatment throughout their stay. They were active partners in their care and made decisions about their treatment during sessions with their keyworker. They completed core work for each of the seven core values, with regular support from staff. In the later stages, this included encouragement to access outside activities that the client had an interest in. They were supported to access mutual aid support groups. We saw evidence of, and talked to clients, who told us they were fully involved in developing plans and planning outcomes.

Clients were involved in the running of the house. They were allocated trusted roles, such as community leaders, head of house, gatekeeper and safe guarder. Every month, the clients chose who should be allocated these roles,

depending on the level of motivation they had shown in completing the programme. The community leaders and safe guarder reported issues to the shift handover meeting. The provider gave clients training and guidance for these roles so that they were able to undertake them effectively. Clients also took responsibility for household tasks such as budgeting, cooking and cleaning.

Clients had the opportunity to make suggestions, raise concerns and make requests. There was a complaints and compliments book and a suggestions box so that clients could raise issues anonymously if they wished. These were considered at the community meeting and, following discussion, a decision was made by the whole community. Community meetings were often led by and minutes made by clients.

We saw the compliments book which had been filled in by family members and friends. There were 30 separate entries for the last 12 months, which were positive about the contribution the service was making and specific compliments about staff members and support offered.

On discharge, clients completed a quality questionnaire that gave staff feedback on the service they provided. We saw completed copies of these and notes from meetings that showed client's feedback had been considered and acted on.

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

Access and discharge

Clients were admitted to the service usually following a planned, completed detoxification programme. The admission process usually began prior to detoxification. Clients were able to visit the service and speak to staff and other clients. They were encouraged to attend for half a day or a day and sit in on a group if they felt comfortable with this. This enabled the provider and clients to explain how the treatment programme worked and ensure that the individual understood the underpinning ethos. This included an explanation of the house rules and expected standards of behaviour. Clients were required to consent and accept these rules before admission.

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Staff worked with each client's care coordinator to identify an admission date in conjunction with a planned detoxification. Clients attended immediately following detoxification. Following completion of detoxification, staff would accompany clients from their previous placement to the service.

The treatment programme extended over a period of six to nine months. This corresponded to the funding available for clients. Discharge planning began on admission. Staff worked with the client and the referral agency to plan discharge dates. Clients were encouraged to consider their objectives following discharge and these were incorporated in to their care plans. This included developing support networks, coping strategies and recovery capital. Following discharge, there were opportunities for clients to stay in accommodation owned by a partner organisation and receive aftercare from the provider group.

There was a policy that provided guidance on discharge, including unplanned discharge. Clients would be encouraged to stay and work through reasons for wanting to leave. If they were adamant that they wished to leave, staff would complete a plan with them including organisations they could contact and contingency arrangements. If clients left in highly risky situations, for example, if highly distressed or in the middle of the night, staff would consider whether the police needed to be notified in terms of vulnerability and whether others, for example, family members needed to be informed. We saw evidence that appropriate actions were taken in these circumstances.

The facilities promote recovery, comfort, dignity and confidentiality

There were communal areas and lounges as well as confidential areas used for group work and therapy sessions. There was access to well-maintained outdoor spaces including a vegetable garden.

Clients could personalise their bedrooms with their belongings. All bedrooms had secure storage spaces and lockable storage for medication. Staff could safely store personal items if needed. Televisions, radios or stereo equipment were not allowed in bedrooms. There was a

television within communal areas but this was restricted to set times outside therapeutic group work and activity. These house rules were explained to clients prior to admission.

The clients contributed to the preparation of all meals via a rota. The focus was upon sharing core daily living tasks and eating meals together as part of the therapeutic environment. Clients could make drinks and snacks outside this time but were not allowed to take these into groups. The menu was set on a four week rota. Recipes and shopping lists were accessible to ensure that menu options could be made by clients. These were used to shop during the week and ensure required ingredients were available.

Clients were not allowed to bring mobile phones into the service. This was a core requirement of admission and was agreed by all clients prior to accepting a place. When not engaged in the daily therapeutic programme clients could make private phone calls and a payphone was available for clients to use.

The treatment programme provided activities for clients seven days a week. There was an activity rota on display. Activities varied from treatment based exercises and group sessions to communal and social activities such as quizzes, group walks and movie nights. There was an out of hours psycho-educational programme that consisted of a wide range of topics. The rehabilitation programme included free time and dedicated time for clients to spend with their key worker. There were journal sessions every morning where clients reflected on the previous day and their feelings. Clients we spoke with told us that they found the activities beneficial and relevant to their needs.

The provider also facilitated monthly trips that staff discussed and agreed with the clients, such as swimming. There was an annual working holiday known as "base camp", where staff and clients took part in voluntary conservation work with the National Trust and received certificates for this.

Meeting the needs of all people who use the service

Information on local services and recovery projects was on display and available from the provider. This helped clients to develop their recovery capital and support network.

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Adjustments were made according to need and agreed at the pre-admission assessment, for example, mobility issues. The service could accommodate wheelchair users and would assess for additional equipment and aids needed before admission.

Cultural and religious needs were identified through assessment. This allowed the provider to identify in advance if interpreter services were required to work with the client and to allow for this to be organised.

Staff would support individuals to attend local places of worship if this was requested. The provider accepted individuals with a range of religious beliefs. Staff could arrange for specific dietary requirements relating to religious or physical health requirements. They identified such needs in the assessment process, which gave time for the provider to address needs before the client's admission.

Clients were not allowed visitors in the first three weeks of their admission so that they could focus fully on the treatment programme. This was agreed with clients prior to admission. Visits were allowed after this period with family and friends. Child visitors had to be accompanied by an adult and there was a room with toys available for child visits. Supervised visits could be facilitated if necessary. Home leave was not allowed during the first three months. As clients progressed through the programme, restrictions on visits and leave were reviewed.

Listening to and learning from concerns and complaints

The provider had a complaints policy. The policy covered both verbal and written complaints.

On admission, clients were provided with written information on how to complain. Their buddy also provided and reiterated information. Complaints information was displayed in the hallway. Staff would attempt to resolve complaints informally initially.

There was a complaints and concerns book to capture both verbal and written complaints. There had been no formal complaints in the previous 12 months. Informal concerns about the location and or the programme were discussed in community meetings and decisions made by clients and staff together. Complaints were a standing agenda item at team meetings and feedback was given about actions taken. We saw minutes of these meetings that confirmed this.

Are substance misuse services well-led?

Vision and values

The aim of the service was to promote recovery and work with clients to develop the skills they needed to maintain their recovery and live independently.

The service identified seven core values which underpinned the treatment programme, these were

1. Realisation and understanding
2. Re-connection and communication
3. Processing and integration
4. Personal responsibility – Choice Theory
5. Building resilience and relapse prevention
6. Re-establishing order and practical everyday living support
7. Consolidation and psycho-educational input

All staff knew the values and vision for the service. Staff felt included as part of the wider organisation. They attended meetings where service developments were discussed every month.

Staff understood the principles of the treatment programme and about how their work linked in.

The clients we spoke with told us that staff were approachable and caring.

Good governance

The nominated individual was attending to the delivery of the regulated activity prior to the trainee manager making an application for registration.

There was a good governance structure to oversee the operation of the service.

There was a 12 month clinical governance plan that included quality areas such as health and safety, risk assessment, client satisfaction, care planning, service reviews, and training and development. The service received support from the external verifier to develop this. The plan and all actions were completed and up to date.

Staff received appropriate appraisal and supervision. Staff received management supervision and external clinical

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supervision at least every month. Staff told us that they were supported by their supervisors as well as by their peers. We looked at records that supported this. The records we reviewed were all up to date.

The service manager and nominated individual were aware that staff training was not up to date and were in the process of arranging a different elearning provider, which would include access to all the mandatory training modules and other training, including training in the Mental Capacity Act.

We reviewed two personnel files and these contained appropriate documentation, including evidence of references and disclosure and barring service checks.

Staff completed regular audits, monitored by the managers. Assessments, care plans and risk management plans were audited to ensure they were completed and reviewed regularly. There were a number of environmental audits completed. We saw evidence that audit findings were addressed quickly.

Staff knew who the managers were and throughout our inspection, we saw them working with staff as part of the team.

Leadership, morale and staff engagement

All staff felt well supported by their colleagues, manager and the organisation. They felt respected, valued and supported, and were positive about their work. They reported good team working.

All staff felt their work was worthwhile and fulfilling. Morale was good and staff said they felt motivated. Some said their work supported their own recovery. Staff were proud of the service as a place to work and they spoke highly about the culture.

There had been no staff sickness in the 12 months before this inspection.

Staff were encouraged to discuss issues and ideas for service development within supervision, community meetings and with the managers. We saw records that confirmed this.

Commitment to quality improvement and innovation

The provider responded to feedback from clients who used the service, staff and external agencies. Clients were asked for feedback on finishing the programme, and they were encouraged to make suggestions during their stay. These were discussed at community meetings. There was strong collaboration and support across the service and a common focus on improving quality of care and clients experiences.

The national drug treatment monitoring system and the level of unplanned discharges were used to monitor the effectiveness of the service. There were plans in place to reduce the number of unplanned discharges from the service.

The provider carried out regular audits throughout the year, with timed action plans for improvements based on the findings. These were complete and up to date.

Outstanding practice and areas for improvement

Outstanding practice

There was an annual working holiday known as “base camp”, where staff and clients took part in voluntary conservation work with the National Trust and received certificates for this.

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that all staff complete mandatory training.
- The provider must ensure that there is a policy relating to the Mental Capacity Act.
- The provider must ensure there is a policy relating to the Duty of Candour.

Action the provider **SHOULD** take to improve

- The provider should make arrangements for a manager to be registered with CQC.
- The provider should consider offering training for staff in basic substance misuse and addiction.
- The provider should ensure that staff receive training to understand the Mental Capacity Act.

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	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>Providers must make sure that staff who obtain the consent of people who use the service are familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005, and are able to apply those when appropriate, for any of the people they are caring for.</p> <p>How the regulation was not being met:</p> <p>There were no policies to guide staff in applying the Mental Capacity Act.</p> <p>This was a breach of regulation 11 (1).</p>
Accommodation for persons who require treatment for substance misuse	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs</p> <p>How the regulation was not being met:</p> <p>Mandatory training was not complete for staff due to changes in the training provider.</p>

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 18(1).

Regulated activity

Accommodation for persons who require treatment for substance misuse

Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Providers must operate effective systems and processes to make sure they assess and monitor their service

How the regulation was not being met:

There were no policies to guide staff in applying the Duty of Candour.

This was a breach of regulation 20.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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