HOPE Worldwide

1st Stage House

Inspection report

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

Ratings

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

Summary of findings

Overall summary

- The service provided safe care. Staff assessed and managed risk well and followed good practice with respect to safeguarding and incident reporting.
- Staff developed care plans informed by a comprehensive initial risk assessment upon admission. They provided a range of treatments that were informed by best-practice guidance and suitable to the needs of the clients.
- Staff discussed ways to improve the service and create new pathways into the service and made contacts in the community to facilitate this.
- The team and leadership group were stable and had been in place since the previous inspection in 2017. The registered manager ensured that these staff received training, supervision and appraisals. Staff worked well together as a team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of clients.

However:

- The annual fire risk assessment was overdue, and staff had not acted promptly to implement recommendations from the previous fire risk assessment. This raised the risk of harm should there have been a fire outbreak. The provider addressed this concern during the inspection.
- Updates to client risk assessments were not always recorded in their care plans, which meant this information was not always easily accessible to staff.
- Some areas of the residential premises were dusty and unclean and some repairs had not been completed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services	Good 	We rated it as good See the summary above for details

Summary of findings

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Summary of this inspection

Background to 1st Stage House

1st Stage House is a male only residential rehabilitation service for up to eight men with a history of substance misuse issues. Clients must complete a detoxification programme prior to admission and be abstinent. At the time of the inspection there were three clients using the service.

The service is provided by HOPE Worldwide and the 1st Stage House forms part of their "One Day at a Time" programme. At the time of our inspection there were three clients using the service. Client treatment costs were funded by the client's local authority or by the client. The "One Day at a Time" programme is based on a model of recovery which is being used in the United States of America. As part of the programme, clients are offered therapeutic interventions and appointments with their key worker at the day service which is located nearby.

There was a registered manager for the service at the time of the inspection. The service is registered to provide:

• Accommodation for persons who require treatment for substance misuse.

We last inspected 1st Stage House in August 2017. At that inspection we found concerns about the safety of the service and issued a number of requirement notices. During this inspection, we found that the service had addressed these concerns. The previous inspection was not rated.

What people who use the service say

Clients' feedback about the service and staff was very positive. Clients reported that staff treated them well and with compassion. A 'buddy' was allocated to clients when they first moved in. This helped clients to establish relationships with more senior clients. Clients described how staff treated them well through the duration of their stay and looked after them.

We saw staff spending time with clients in the communal areas during the day and speaking to clients in a friendly and respectful manner.

How we carried out this inspection

During the inspection, the inspection team:

• conducted a review of the environment of the residential house and the day service based at premises nearby

• spoke to the registered manager of the service

• spoke with three other staff members employed by the service provider, including the therapy manager and housing manager

• spoke with two peer support volunteers

• spoke with two clients

Summary of this inspection

• reviewed all three client records

• looked at a range of policies, procedures and other documents relating to the operation of the service

The inspection team consisted of a lead inspector and another inspector.

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

Outstanding practice

We did not find areas of outstanding practice.

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that annual fire risk assessments are updated on time and actions from fire risk assessments are completed promptly. (Regulation 12(2)(d))

Action the service SHOULD take to improve:

- The service should record reviews of clients' risks clearly in their care plans
- The service should ensure that the cleanliness of the residential house is maintained, including regular deep cleans, and that any repairs required, and maintenance are actioned promptly

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Residential substance misuse services

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

Are Residential substance misuse services safe?

Requires Improvement

Safe and clean environment

The service had not updated the annual fire risk assessment and actions from the previous assessment had not been completed. The premises where clients received care was safe, clean, well-furnished and fit for purpose. The residential house was safe and fit for purpose. However, some areas of the residential premises were dusty and unclean and some repairs had not been completed.

1st Stage House provided accommodation for clients whilst they undertook psychosocial therapies for their substance misuse issues. These therapies took place at a different site. We inspected both sites. The site where therapies took place was safe, clean and fit for purpose. The registered manager told us there were plans to repaint the walls at this site.

The residential house where the clients lived was located at the registered location. There was a fire safety policy in place. The most recent fire risk assessment at the residential house took place in February 2021, 16 months prior to the inspection. Two action items from the previous assessment had not been completed. This was to add a fire extinguisher to the kitchen and remove a fire blanket. Not completing these actions raised the risk to client's safety in the event of a fire. Following our inspection, a fire risk assessment took place on the 17 June 2022 and the premises were judged to be safe.

The house was dusty and unclean in places, and there were outstanding repairs that needed to be completed. The clients were responsible for cleaning this house as part of their recovery and had a cleaning rota in place for this. The sharps bin and clinical waste bin were covered in dust. The tiling had not been finished in the bathroom. A cupboard door in the kitchen needed repairing. These repairs were included in weekly team meeting minutes as action items but had still not been actioned. We were told the service was 'deep' cleaned periodically, but we only saw evidence that carpet cleaning had taken place.

The provider had an infection control policy which highlighted the procedures for the prevention of spreading infectious diseases. It included bodily fluid spillages and hand washing techniques. Handwashing facilities were available for staff. The service did not undertake infection control audits.

Records confirmed that staff carried out regular environmental checks. Staff also carried out monthly checks on first aid box, carbon monoxide testing log, fire drills, alarm call log, emergency lights and the smoke detector. Portable appliance testing took place annually.

The provider had an effective clinical waste management system to safely discard waste from urine screening tests undertaken to ensure that clients had not used substances that were prohibited by the service.

We found that food was labelled in the fridge and in date. Food was stored in airtight containers and cooked and uncooked foods kept in separate areas of the fridge.

Safe staffing

The service had enough staff, who knew the clients and received training to keep them safe. The number of clients was low at the time of inspection, which gave staff time to give to clients as they needed.

The provider had enough staff to keep clients safe. The service had four full time staff and three volunteers working Monday to Friday. There was an additional volunteer counsellor, and two paid contracted counsellors that would fill in when the service was short of staff. This was only between office hours Monday to Friday and rarely happened.

The input provided by volunteers was significant. Since November 2021 one volunteer would stay the night at the residential house on a rotating roster to provide support to the clients. The residential house was otherwise not staffed in the evenings and at weekends. Volunteers also provided out of hours on call support to clients. The on-call rota would always have one paid staff member and one volunteer. The registered manager was on-call in emergencies.

The paid staff and counsellors provided therapy groups and management roles. Volunteers provided support to clients through regular key working sessions and support with household duties. The service did not use any agency or bank staff to cover shifts. Client therapy groups were never cancelled due to shortage of staff. The service did not have any turnover of staff or vacancies in the last 12 months.

The service conducted disclosure and barring service (DBS) checks on all staff. We reviewed the employment records and all staff had their DBS up to date. We were told all staff had had reference checks when they began working in the service but there was no record of this. There had been no staff turnover since the registered manager began working at the service, and they told us they would record any future reference checks. Reference checks help provide assurance for the service that the staff member is suitable for the role and to keep clients safe.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The managers monitored mandatory training and alerted staff when they needed to update their training. The manager planned to add this as a standard item to the weekly team meeting agenda to assist with monitoring completion rates.

Assessing and managing risk to clients and staff

Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in a client's health. Staff worked with clients to develop crisis plans. Staff discussed risks to clients in team meetings but these were not always clearly recorded in the clients' care plans.

Assessment and management of client risk

We reviewed three client care records. When clients were referred to the service the staff assessed the potential risks to the client and staff. A comprehensive risk assessment was completed upon admission to the service. This included a full

risk history including risks of sex working, domestic violence and blood-borne viruses. A blood-borne virus is a disease that can be spread through contamination by blood and other body fluids. Risks to clients were discussed weekly during team meetings and key worker sessions. These were recorded in team meeting minutes. However, updates in relation to risks, or evidence of review, were not always recorded in clients' care plans. This meant the information may not always be easily accessible to staff.

Each client had a crisis management plan, and these were appropriate. For example, the plans gave information about who to contact in an emergency or in the case of a relapse or overdose and who to call including care managers. Following a client death in June 2021 the provider ensured clients had a clear unplanned exit plan in place which outlined what staff would do in the event that a client breached the rules of the programme and had to leave. This included ensuring that the client would be supported in the community by contacting other organisations including the local homeless persons unit upon leaving the programme early and offering Naloxone to clients who were discharged after a relapse. This would help manage the risk to the client if they relapsed.

There was naloxone in place for clients at the residential house and at the site where therapies took place. Naloxone reverses the effects of an opioid overdose.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff had liaised with different health and social care professionals to meet the needs of clients. The provider's policy required all safeguarding alerts to be recorded and reported through NHS systems or local council systems. The service would then notify the CQC and the police. Safeguarding was a standard agenda item for weekly team meetings.

All staff and volunteers completed training in safeguarding vulnerable adults and children from abuse. Staff understood that clients with a history of substance misuse problems and mental health needs could be at risk of abuse from others.

Staff access to essential information

Staff had easy access to records of clients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Prior to the pandemic the service had used mostly paper records and policies. However, since then the service had moved their policies and procedures online. Paper records were still used for client care records and these were stored securely in the staff office to manage the risk to confidentiality of information. Staff had all relevant information needed to deliver care to clients.

Medicines management

The service used systems and processes to safely monitor clients' storage and self-administration of medicines.

The service had a management of medicines policy in place. The service did not store medicines and staff did not administer medicines. The management of medicines policy was in accordance with best practice guidance from NICE. When clients were admitted to the service they were assessed as to whether they could self-administer medicines. Clients had their own combination safe in their bedrooms to store their medication. Staff kept the keys to this safe. Pictures of the medications were added to the client's records.

Good

Residential substance misuse services

The service did not admit clients that could not self-administer. Two clients were self-administering their medicines at the time of the inspection. We reviewed the weekly medicines monitoring form and this was being checked and signed by the volunteers with the clients, and then reviewed by the manager

The service used a weekly medicine monitoring form to monitor clients' medicine self-administration. This was in clear format and used a weekly stock count of the client's medicines to monitor that they were taking them as frequently as required. The volunteers supported clients to complete a weekly stock check of their medicines and gave this to the registered manager to review.

If a client wanted to alter or stop taking their medicine the service would refer them to their GP before the client made any changes.

Track record on safety

The service generally had a good track record on safety. However, there was an incident in June 2021 where a client died two days after they had relapsed and left the service early.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. The manager investigated incidents and shared lessons learned with the whole team.

The provider had an incident reporting system in place. Staff used incident reporting processes appropriately. Staff knew what incidents to report and how to report them. Volunteers reported any incidents from the house to their line manager who then completed an incident form.

There were two incidents reported in the previous 12 months. One incident involved a client death after they had used alcohol and left the service early. The other incident was a client was found smoking in the residential house.

Incidents were included as an agenda item at the team meetings and there was evidence of learning from incidents as a result. For example, after the client death there was an investigation into this and learning included ensuring all clients had a clear, documented exit plan before admission, and confirming the client's list of people to contact in an emergency was on their client file. Where a client was found smoking inside the residential house learning included staff reviewing how to approach an agitated client.

Are Residential substance misuse services effective?

Good

Assessment of needs and planning of care

Staff assessed the mental health needs of all clients. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised and recovery oriented.

Staff completed comprehensive assessments of clients on their admission. The assessment included sections such as their medical, financial, blood borne virus status, domestic violence, mental health, physical health and social care

needs. We reviewed three care records in detail. The therapy manager completed the risk assessments and the keyworkers completed the care plans with the clients. Staff and volunteers supported clients through regular key working sessions and daily contact with the clients. Key workers updated client care plans on a weekly basis. There was evidence that keyworkers discussed medicine changes and recovery goals with clients.

Best practice in treatment and care

Staff provided a range of treatment and care for clients based on national guidance and best practice. They ensured that clients had good access to physical healthcare and supported them to live healthier lives.

The service based its model of care on a programme used in the United States called One Day at a Time (ODAAT). It was a structured programme with therapeutic input, which emphasized the importance of peer support and personal accountability. The purpose of the 1st Stage House programme was to provide a safe, closely managed structure for clients in their early days of recovery. After clients had completed three months at 1st Stage House, they continued their therapy programme at the provider's 2nd stage house. At the time of the inspection there were no clients at 2nd Stage House as due to the impact of the recent pandemic there had been fewer referrals to 1st Stage House.

Staff understood the physical health needs of the client group. Shortly after clients were admitted to the service they were registered with a local GP. Clients also had the option of staying with the GP they were already registered with if they preferred. Staff in the service liaised with secondary health care services as necessary. For example, when clients needed to attend appointments at local acute hospitals. The staff shared information with these services with the consent of the client. Care plans included the physical health needs of the client and addressed any physical health problems they had.

The volunteers were available to accompany clients if they had appointments or wished to go for a walk or shopping. The activities timetable was posted in the reception area. The clients also had access to a range of activities and were encouraged to get fit and healthy as part of their recovery. Activities included yoga sessions and local walks.

Clients cooked together. Clients were expected to work together to provide food shopping for the entire house, this was part of their recovery programme.

The service kept a stock of naloxone for clients at the recovery house. The naloxone was clearly displayed in the house, was in date and appropriate for use. However, the container storing this was worn and needed replacing. This was escalated to the registered manager during the inspection, they advised they would replace this. Staff, volunteers and clients had received naloxone training should they need to use it.

The service provided care and treatment based on national guidance and evidence of its effectiveness. In accordance with the National Institute for Health and Care Excellence (NICE) guidance, the service provided cognitive behavioural therapy and psychodynamic therapy for clients from either qualified counsellors or counsellors in training. The service provided a number of self-help groups, which included relapse prevention and anger management. The therapy manager ran these groups and received appropriate external supervision. The client timetable included therapeutic and group work sessions; these included one to one counselling sessions, anger management, relapse prevention, reflection group and yoga.

The service encouraged clients to attend external self-help groups and staff told us clients attended alcohol anonymous, narcotics anonymous and cocaine anonymous. Clients attended these groups in the community, which gave clients the opportunity to receive support from individuals who were abstinent from drugs and alcohol and were positive role models.

The service did not offer smoking cessation sessions but supported clients who wished to stop smoking by signposting them to appropriate services.

The service provided an offsite group activity every six to 10 weeks during the pandemic. For example, the manager recently took a client rock climbing.

Monitoring and comparing treatment outcomes

Staff reviewed care and recovery plans with clients weekly to monitor their progress in treatment.

Staff met with clients individually every week to review the previous week and discuss plans for the upcoming week. Since the start of 2022 the service had started collecting data to monitor tenancy sustainment, and education, training and employment outcomes for clients.

The registered manager told us that approximately one third of clients that were admitted to 1st Stage House completed the programme and progressed to the 3rd Stage House without relapsing. The service took part in an alumni programme with Georgetown University that used a software tool to assist programme graduates to keep in contact with the service and each other and assist the service in monitoring their progress over time.

Skilled staff to deliver care

The team included the full range of specialists required to meet the needs of clients under their care. The manager supported staff with appraisals and supervision.

The service had specialist training modules. The staff had recently undertaken breakaway training in January 2022. The manager had attended a seminar on tackling drug addiction and substance misuse in June 2021.

The service supported volunteers to enroll onto a level 3 diploma in health and social care with an emphasis on substance misuse. This supported volunteers to receive training to enable them to undertake their role and also supported with their professional development. The service had recently implemented a fortnightly reflective group for the volunteers.

Staff received one to one supervision each month. All staff had received an appraisal in the last 12 months. Staff appraisals included conversations about learning and development and how it could be supported. For example, we saw managers had supported volunteers to enroll onto a substance misuse diploma to assist with their career progression.

Volunteers were supported by more senior staff in group reflective practice. These had been sporadic due to the pandemic, but the service was working on holding these fortnightly. There was an induction program for new staff.

The team met weekly to discuss the clients and any other issues or concerns in the service.

Multidisciplinary and interagency teamwork

Staff worked together as a team to benefit clients. They supported each other to make sure clients were cared for. The team had effective working relationships with relevant services outside the organisation.

Good

Residential substance misuse services

Staff handed over information to each other about clients throughout the day. This handover was not recorded. The service was small, and staff were able to update the rest of the team as and when situations arose. Staff said the on-call manager was always available to handover information.

Staff attended regular team meetings. Minutes from these meetings demonstrated that there was a standard agenda which covered topics such as staffing, complaints and incidents.

The service had arrangements for multi-agency working. We saw clear and regular communication with clients' care managers. For example, regular meetings took place between care managers and staff to update on their progress.

Staff supported clients who had mental health needs to get appropriate support.

Adherence to and good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the provider policy on the Mental Capacity Act 2005.

Staff received training related to the Mental Capacity Act (MCA) and deprivation of liberty safeguards. Training completion rates were 100% for all staff and volunteers.

The service had a mental health policy, which included the MCA. The policy provided guidance to staff on the principles of the MCA.

When clients were admitted to the service they verbally agreed to a number of restrictions as part of the therapy programme. Staff ensured that clients understood and had the capacity to consent to these restrictions. Clients had limited contact with their family or friends during the early stages of treatment. Prior to the pandemic clients could not have mobile phones for the first four to six weeks, however limited access to phones was allowed during the pandemic to contact families and carers. Clients could not have a key to the house. Initially, clients were chaperoned by a buddy who accompanied them into the community and gave them access to the house. Clients provided urine samples for drug testing. These restrictions were assessed at regular intervals by the therapy manager. If clients used alcohol or drugs whilst in treatment, they were required to leave the service.

Are Residential substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

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

Staff treated clients with dignity and respect. We saw staff spending time with clients in the communal areas during the day and speaking to them in a friendly and respectful manner.

On admission all clients signed consent to treatment and to share information forms. This was included as part of their welcome pack. We saw in the records that each client had signed a confidentiality agreement with the service. All clients received a welcome pack upon admission.

Good

Residential substance misuse services

We spoke with two clients. Feedback from clients confirmed that staff treated them well and with compassion. Clients described how staff treated them fairly throughout the duration of their stay and felt respected.

Staff provided emotional support to clients to minimise their distress during admission. For example, the therapy manager supported a client at his home to pack his belongings ready for admission to the service.

Staff implemented a cooked lunch Monday to Friday for the clients and staff to rebuild the community spirit within the service.

Staff understood the needs of the clients. Staff knew the importance of abstinence within this client group and supported them to maintain this.

Involvement in care

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Involvement of clients, their families and carers

Staff involved clients and those close to them in decisions about their care and treatment. For example, each week clients met with their key worker to discuss their progress and identify goals for the week.

Staff appropriately involved clients' families in their care. Staff assessed clients' family relationships at admission. During the first few weeks of admission clients were restricted access to family members, this was to support with the recovery process. However, staff understood the need to support clients connect with their families. For example, clients described when staff had supported them to maintain contact with their family and reconnect.

Clients were able to give feedback about the service they received both formally and informally. Staff gathered feedback regarding the service by asking the clients to complete feedback forms and verbally at the end of therapeutic sessions and during activities. Additionally, clients could give feedback in the monthly service user forums, which was led by the support manager at the day service. This had a standard agenda and the provider used the feedback to improve the service. For example, clients fed back that they would like somewhere covered outside at the residential house so they could use the backyard when it was raining. The service provided a gazebo that the staff and clients built together.

Are Residential substance misuse services responsive?

Good

Access and waiting times

The service was easy to access. However due to the impact of the recent pandemic there had been fewer referrals to the service as the services that would normally refer to this service had been closed. This service was working on establishing new pathways into service with new care providers.

Staff were able to assess prospective clients in a timely manner. There was no waiting list for this service. The service was in the process of speaking to commissioners to establish new pathways into the service. In 2021 the service had partnered with Guy's and St Thomas' NHS Foundation Trust to book and pay for beds in their detox service to create a pathway into the service, and two clients were admitted through this.

The average stay for clients was six months. Overall, across services provided, including 2nd and 3rd stage houses, the average stay was 18 months to two years. The 3rd Stage House provided ongoing supported accommodation and unlimited ongoing group aftercare as part of the programme. The service had access to an alumni program so that clients could maintain the connections formed during their admission. The service had an annual reunion day for all clients past and present, and used an online program that provided a membership forum that enabled former clients to stay in touch.

Funding for treatment came from a variety of sources, which included donations, clients and local authorities.

The service had an admissions policy that outlined it would only admit men aged 18 and over and who were abstinent from drug and/or alcohol. The policy outlined it admitted men with low support mental health needs only.

At the previous inspection in 2017 the admissions policy did not clarify what low support mental health needs meant. At this inspection the admission policy stated that the service was best placed to help clients whose mental health issues arose from their drug and alcohol addiction rather than prior and well established serious mental health issues. Therefore, staff had guidance as to what low support mental health needs meant and admitted appropriate clients.

The provider had a 2nd Stage House which clients moved on to continue their recovery programme after they had completed their first three months at 1st Stage House. At the time of inspection there were no clients at 2nd Stage House.

The facilities promote comfort, dignity and privacy

The treatment rooms supported clients' treatment, privacy and dignity.

Clients took part in therapy sessions, one to one meetings or group work sessions at the day service located at different premises nearby. Clients used a local bus route to travel from the house to the day service. The facilities available to clients at the registered location were a communal lounge, dining room, kitchen and garden, which were accessible 24 hours a day.

Clients did not have access to a private telephone or their own mobile in the first four to six weeks of their stay. The service had a pay phone that clients could use to call emergency services and staff out of hours if they did not own a personal mobile. This was in the main corridor of the house.

The house was non-smoking. If clients wished to smoke, they could do so in the garden.

Clients' belongings were stored securely. Items of value could be stored in the service's safe. The service kept a log of the items that were stored in the safe. Clients were able to personalise their bedrooms. Clients shared bedrooms as part of the therapeutic model, encouraging mutual support.

Meeting the needs of all people who use the service

The service met the needs of all clients – including those with a protected characteristic. Staff helped clients with communication, advocacy and cultural and spiritual support.

The service was a faith-based organisation but supported clients from different faiths, as well as LGBTQ+ clients. It was flexible with the therapy programme to accommodate clients' spiritual needs. For example, the service planned group times for a client, so they were able to attend mosque, in line with their faith.

Good

Residential substance misuse services

The day service was not accessible to people who used a wheelchair. If a prospective client was identified as having mobility difficulties, they were signposted to other substance misuse services by the provider.

Staff delivered group work and therapy sessions in English. However, the service was able to access an interpreter when needed. They would also connect the client to other clients or former clients who spoke the same language if possible.

The service cooked food according to the clients' preferences. For example, the service had had vegetarian clients in the past and the staff would cook vegetarian food for them.

Listening to and learning from concerns and complaints

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

The service had a complaints policy. Information on how to complain was readily available to clients. This information was contained in the service admissions pack. Clients told us they knew how to complain. Staff encouraged clients to raise concerns, complaints and compliments during monthly service user forums. Staff responded appropriately to issues raised by clients and tried to resolve them. For example, a complaint made by one client against another resulted in the client who had the complaint made against them working as a gardener for the service to work off a debt.

The service had not received any complaints in the last 12 months.\

Are Residential substance misuse services well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service they managed and were visible in the service and approachable for staff. Clients told us they felt supported and cared for by leaders and staff.

The service had a two-tier leadership model, which consisted of a trustee board and a senior management team. The provider had recently recruited a specialist substance misuse nurse to their trustee board, who provided advice on medicines.

The senior management had remained stable and had been with the service for a number of years. They had a variety of skills, knowledge and experience to perform their roles. Senior managers had a good understanding of the service they managed.

Senior managers were visible in the day service and volunteers and clients said they were approachable.

Vision and strategy

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

Good

Residential substance misuse services

The service had clear vision and strategy that all staff understood and put into practice. The service's vision and values were rooted in their faith-based ethos. The aim was to assist people who were in difficulty, to support clients to make changes in their lives and to help them make a new start.

The provider was in the process of establishing new relationships with London based detox providers to create new pathways into the service. The recent pandemic had closed many of the services that had previously referred clients to this service.

Culture

Staff felt respected, supported and valued. They could raise any concerns without fear.

The team was small, and staff were able to communicate with each other effectively. The senior management had remained stable and been with the service for a number of years. All staff we spoke with told us how they had worked at the service for a long time and felt it was a supportive place to work.

The service had a whistleblowing policy that detailed how to report bullying and harassment. Staff told us they felt able to raise issues with their manager or the director where appropriate. Staff did not report any bullying or harassment at the service.

The service had low levels of sickness and no staff on long term sick

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

There were systems and procedures to ensure that the premises were safe and there were enough staff that were trained and supervised. There were bimonthly health and safety audits to monitor the residential house. However, these were not always effective as the residential premises were not kept very clean, and there were ongoing outstanding repairs such as fixing a cupboard in the kitchen and tiles in the bathroom.

Clients were comprehensively assessed and treated well. Staff reported incidents. Incidents were investigated and learned from.

The manager of the service attended fortnightly senior management meetings. We reviewed the meeting minutes. Topics of discussion included the operational running of the recovery service, client outcomes, staffing, complaints and incidents. This meant that there was oversight, sharing of relevant information and learning across the organisation.

There was a clear agenda of what was discussed in weekly team meetings to ensure essential information was shared. For example, complaints and safeguarding concerns were discussed and shared.

Staff understood arrangements for working with external teams, such as the local authority and other health care providers to meet the needs of the clients.

Management of risk, issues and performance

There were effective systems in place to manage risk and issues to the service.

The service had a risk register in place. This was a comprehensive risk register that had a staff member accountable for the actions identified. For example, risk of falsifying urine tests was included on the risk register with training for staff to verify urine tests. The risk of food poisoning was also included on the risk register with checks put in place by the senior house resident to mitigate this risk.

The service had a business continuity plan in place to support staff and clients in case of emergencies.

Information management

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

Staff and volunteers had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well. Team managers had access to information to support them with their management role. This included information on staffing and client care.

Engagement

The service engaged with patients and staff to plan appropriate therapies and make improvements to the service.

Senior management actively engaged with staff and volunteers in regard to changes on the services policies and procedures. Staff were engaging with London based detox services to create new pathways into this service.

Staff, volunteers and clients had access to up-to-date information about the work of the provider and the service they used. For example, there were information leaflets about the programme in the day service.

The service was small so staff were able to provide feedback about the service during team meetings and directly to the manager. Staff told us they felt comfortable doing this.

Clients provided feedback through feedback forms, during key work sessions and informally with staff. The service used this to make improvements to the service. Clients were involved in maintenance of the residential house such as gardening and cleaning.

Learning, continuous improvement and innovation

The service shared learning from serious incidents. Staff collected and analysed data about outcomes and performance of the service.

Learning from serious incidents took place during weekly team meetings, staff supervision and reflective practice.

The managers and staff embraced change and worked to improve the sustainability of the service. Staff worked on ways to create new pathways into the service. The provider had a vision and mission for recovery services. This set out objectives that the service wanted to achieve within the next three years.

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 The service did not ensure that annual fire risk assessments were completed on time, and that actions from fire risk assessments were completed promptly.

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.