Rhodes Recovery

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Rhodes Recovery as good because:

- The service provided safe care. The premises where clients were seen were safe and clean, although cleaning records were not kept. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Clients self-administered their own medicines and kept them locked away in their bedrooms. Staff carried out audits on clients' medicines to ensure they were taking them appropriately.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. The service provided a 12-step abstinence-based rehabilitation programme for people recovering from drug and alcohol addiction that national guidance recommended for supporting recovery. Staff used psychoanalytical approaches and psychodrama to support clients with their recovery. Clients also participated in equine therapy, drama and yoga as part of their recovery.
- The team included or had access to the full range of specialists required to meet the needs of clients under their care. Staff received specialist training to support them in their role in addictions, including motivational interviewing and relapse prevention. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. They actively involved clients in decisions and care planning. Clients provided positive feedback about how staff treated them and said staff knew the issues they faced in their recovery. Staff involved clients' families in their care and treatment through regular face-to-face meetings. Clients were able to contact staff after they had left if they needed support over the telephone.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet. Staff provided an aftercare programme once clients had moved on from the service. This included a one-hour weekly session and invitations to annual celebrations.
- The service worked towards a model of rehabilitation and abstinence. The service was well managed, and the governance processes ensured that its procedures ran smoothly to operate a successful service for clients.

However,

- The registered manager did not always make notifications to external bodies as needed. We found three notifiable incidents, including two allegations of abuse in relation to service users, that had not been notified to the Care Quality Commission.
- Not all clients had a written early exit plan to ensure they knew what to do if they relapsed or left the programme early. Although staff and clients were able to explain what would happen if a client left the programme early.
- The provider did not stock emergency Naloxone medicine despite admitting clients who presented with risks for illicit opiate and substance misuse and had not risk assessed the need for this.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	

Summary of findings

Contents

Good

Rhodes Recovery

Services we looked at
Residential substance misuse services

Summary of this inspection

Background to Rhodes Recovery

Rhodes Recovery is a private residential rehabilitation service for up to 16 men and women. The provider is Partnerships in Care 1 Limited, part of the Priory Group. At the time of our inspection there were five men and women using the service.

Clients were self-funded. The service opened in October 2018.

Treatment at Rhodes Recovery is abstinence-based. The service provides psychosocial support and does not provide detoxification. Clients requiring detoxification attend a different service before their admission to Rhodes Recovery. The service only takes clients who have undertaken a recent 28-day inpatient detoxification programme and have been abstinent for a minimum of two weeks.

At the time of the inspection there was a registered manager in place.

The service is registered to provide accommodation for persons who require treatment for substance misuse.

This was the first inspection of the service.

Our inspection team

The team that inspected the service comprised of a CQC inspector, an assistant inspector and a specialist advisor with experience of working as a nurse with people with drug and alcohol addictions.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for clients;
- spoke with two clients and two carers who were using the service;
- spoke with the registered manager
- spoke with four staff members;
- looked at three care and treatment records of patients:
- carried out a specific check of the medication management; and
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

Clients provided positive feedback about how staff treated them and knew the issues they faced in their recovery.

We spoke to two clients and two carers. Clients said that staff treated them well and they felt safe at the service. Throughout the inspection, staff engaged with clients in a positive and supportive way. Staff provided clients with emotional and practical support. Clients said the service had really helped them with their recovery. Clients specifically told us about staff members who they liked and felt able to talk to openly.

The service collected feedback on the service they received from former and new clients. From seven clients providing feedback, the service scored an average rating of 4.6 out of five.

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?

Good

We rated safe as good because:

- The service had enough therapeutic staff to keep patients safe. The manager had successfully bid to have an additional support worker on-call at night because of staff feedback. Staff knew the clients well and received appropriate training to keep them safe from avoidable harm.
- The premises where clients were seen were safe and clean. Staff regularly checked the premises to control infection risk, although did not keep cleaning records.
- Staff screened clients before admission and only admitted them if it was safe to do so. They assessed and managed risks to clients and themselves well. Staff had been trained to respond promptly to sudden deterioration in clients' physical and mental health.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Clients self-administered their own medicines and kept them locked away in their bedrooms. Staff carried out audits on client's medicines to ensure they were taking them appropriately.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

However,

- Not all clients had a written early exit plan to ensure they knew what to do if they relapsed or left the programme early. Although staff and clients were able to explain what would happen if a client left the programme early.
- Staff did not keep a stock of naloxone (emergency drug) on the premises in case a client relapses and overdoses on opioids. Naloxone is a drug used to reverse an opioid overdose.
- Staff did not keep cleaning records to confirm that cleaning was regularly undertaken.

Summary of this inspection

- Staff did not regularly record that they had checked the tumble dryer to ensure it did not overheat and cause a fire.
- Whilst staff had introduced a new tool to asses clients' ability to self-administer their medicines safely, this still needed further embedding.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments with clients on admission to the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. The service provided a 12-step abstinence-based rehabilitation programme for people recovering from drug and alcohol addiction that national guidance recommended for supporting recovery. Staff used psychological therapies and psychodrama to support clients with their recovery. Clients also participated in equine therapy, drama and yoga as part of their recovery.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Staff received specialist training to support them in their role with addictions, including relapse prevention and motivational interviewing.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Are services caring?

Good

We rated caring as good because:

- Staff treated clients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of clients and supported clients to understand and manage their care and treatment.
- Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support.

Summary of this inspection

- Clients were able to contact staff after they had left if they needed support over the telephone.
- Staff informed and involved families and carers appropriately. Staff invited families to weekly meetings to provide a care plan in collaboration with all those involved in the client's care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access, and clients could self-refer. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- Staff provided an aftercare programme once clients had moved on from the service. This included a one-hour weekly session and invites to annual celebrations.
- The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The registered manager did not always make notifications to the Care Quality Commission as required. We found three notifiable incidents, which included two allegations of abuse in relation to service users, that had not been reported to the Care Quality Commission.

However,

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Summary of this inspection

- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Feedback from some staff had been recognised and the service was working actively with staff to respond to their concerns and make changes that would benefit them.
- The service had been proactive in capturing and responding to patients concerns and complaints. There were creative attempts to involve patients in all aspects of the service.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

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

All staff received mandatory training in the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

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

Good

Substance misuse services

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

Are substance misuse services safe?

Good

Safe and clean environment

The service was clean, comfortable and well maintained. The service accommodated up to 16 clients and had only been open since last year, with all new fixtures and fittings. There was a cleaning rota which involved both clients, as part of the model of recovery, and staff members. In addition, a full-time housekeeper cleaned the premises every day. However, staff did not keep cleaning records to confirm that cleaning was regularly undertaken.

The service complied with guidance on eliminating mixed-sex accommodation. The service allocated bedrooms to women in a specific area of the building to ensure that male and female clients did not have to pass washing facilities belonging to the opposite sex. In addition, the service provided a female only lounge.

The service maintained a ligature risk management plan for the premises. Details of identified ligature risks and actions staff could take should anyone use items to create a ligature were listed. Staff kept ligature cutters in their office in case they needed them in an emergency.

The service completed up-to-date annual fire risk assessments and completed actions following the assessment. The building was fitted with fire alarms and smoke detectors and fire exits were clearly marked. Staff carried out fire safety checks including fire evacuation drills with clients. However, these were not regularly recorded as per the provider's policy. The service had a policy that fire safety drills should be carried out four times a year, to ensure the safety of clients and staff. However, records showed fire drills had only taken place twice in 2019 when a total of at least three drills should have been completed. This meant staff had not followed the provider's fire safety policy.

The service had a tumble dryer machine which required daily lint removal to ensure that any excess build up did not overheat the tumble dryer and create a fire. Staff kept a record of this. However, at the time of the inspection, records showed lint removal had not been completed for eight days in November, five days in October, two days in September and 10 days in August 2019. We fed this back during the inspection, and staff said they would immediately ensure all staff completed these checks.

Staff maintained satisfactory food hygiene standards and received training on the safe handling of food and waste. The kitchen contained colour coded chopping boards and refrigerator temperatures were monitored and recorded to ensure safe food storage practices.

Staff adhered to infection control practices such as appropriate hand washing and the disposal of clinical waste in designated bins. Staff completed regular urine drug screen testing on clients to test for illicit substances. Staff disposed of this waste appropriately. The service had an infection control lead and monthly infection control audits took place.

Staff could use accessible resuscitation equipment in case of a medical emergency. For example, the premises had an automated defibrillator (AED) that staff checked regularly to ensure it was working and the pads were in date. In addition, staff kept an emergency grab bag in the staff office in case of emergency. However, staff did not keep a stock of naloxone (emergency drug) on the premises in

case a client relapsed and overdosed on opioids. Naloxone is a drug used to reverse an opioid overdose. Whilst staff called 999 in an emergency, there was no risk assessment in place to demonstrate the decision not to supply a stock of naloxone to clients for their own use.

Safe staffing

The service had enough skilled staff to meet the needs of clients and had contingency plans to manage unforeseen staff shortages. At the time of the inspection the service had a total of 10 substantive staff. The substantive staff team was made up of therapists and therapeutic support workers, one of which was a waking night therapeutic support worker. At the time of the inspection the service had a vacancy for a therapist. The manager was covering this post until they had recruited a new therapist. In addition, the service had two vacancies for support workers.

Staff worked to cover the service all the time. Therapists worked Monday – Saturday, between normal office hours. Support workers worked shift patterns, including daytime, evenings and at night.

The manager block booked the same agency support workers familiar with the service to cover the two vacancies. Sometimes staff from the provider's neighbouring hospital worked bank shifts at the service. The manager made sure all bank and agency staff had a full induction and understood the service before starting their shift. This ensured consistency for clients.

The service had a lone working policy that staff followed. Staff worked on their own in the evenings and at night. The service had a management on-call rota out of hours, so staff had back up support in an emergency. Staff had complained about working on their own and not having enough time to carry out activities at the weekend. As a result, therapists worked at weekends as well to ensure that clients had enough activities. In addition, the managers had successfully submitted a business plan so that they could have an additional therapeutic support worker on-call out of hours. This would ensure that staff lone working could contact another staff member to attend the service quickly if they needed.

Mandatory training

Staff had received and were up to date with appropriate mandatory training. The service designated training on health and safety, safeguarding, first aid, fire safety, food hygiene, medicines management, equality and diversity and dealing with violence and aggression as mandatory for all staff.

Staff also participated in emergency scenario training each quarter. We looked at the emergency scenario training carried out in June 2019 with four members of staff participating in it. This ensured staff would have the practical capabilities and skills needed in an emergency.

Assessing and managing risk to clients and staff

Staff completed regular risk assessments for clients on admission and throughout. We looked at three clients' risk assessments. Staff screened clients before admission and only admitted them if it was safe to do so. For example, clients were only accepted if they had completed an alcohol or opioid detoxification. Referral information was comprehensive and included a report from the individuals' GPs and their primary detoxification service.

Staff completed risk assessments comprehensively, updated and reviewed them regularly with the client. In addition, staff discussed clients' risks daily in the handover.

Management of client risk

Staff mostly supported clients to be aware of the risks of continued substance misuse and safety planning. Risk management plans were in place for each identified risk and were developed with the individual clients. Staff mitigated individual client risks, and these included both mental and physical health risks. Staff reviewed clients' risks regularly in multi-disciplinary meetings and daily handovers.

Staff recognised and responded to warning signs and deterioration in people's health. Client risk assessments detailed associated risks and triggers when their mental health deteriorated. For example, staff managed the risk posed by a client who wanted to leave the programme early through encouragement and by contacting their family. Staff also carried out regular observations of clients if they were at heightened risk of leaving or relapsing. Staff managed another client's risk of poor physical health through liaison with local specialist services. In addition, staff carried out urine drug screen tests and breathalysed clients randomly to ensure clients did not take illicit substances or drink alcohol.

Good

Substance misuse services

Whilst clients and staff were aware of the risks associated with continued substance misuse, not all clients had personalised early exit plans in place. We looked at three client care records and found that two did not contain plans for when a client left the programme early. This meant it was not clear from these two clients records if they knew the risks associated with relapsing and the result of a potentially fatal overdose. We saw one record where staff had created a detailed crisis plan for the client. Staff said in the event of an early exit, they attempted to persuade the client to stay, explain the risks, speak to their next of kin or family members, inform the GP or their consultant psychiatrist and ensure the client signed discharge papers. Clients we spoke to told us they knew the risks associated with leaving early. The manager recognised that this was an area they needed to improve on.

Use of restrictive interventions

Staff applied blanket restrictions on clients' freedom only when justified. The service applied a range of 'house rules' as part of the recovery programme. These rules were in place to keep the clients safe at the beginning of their treatment and staff reviewed these as each client progressed in their treatment. House rules included, restrictions on leave arrangements in the first week and carrying out tests on clients to detect alcohol and illicit substances.

Staff followed good policies and procedures for use of observation and for searching clients or their bedrooms. Staff carried out random checks of clients' bedrooms. Additional checks of bedrooms could be carried out if staff suspected clients had prohibited items. Clients signed to confirmed they accepted these checks as part of the conditions of staying at the service.

Safeguarding

Staff gave examples of how to protect clients from harassment, discrimination and abuse, including those with protected characteristics under the Equality Act. For example, staff told us how one client attempted to kiss another client. Staff described how they raised this with the site manager, who then raised it to the local authority safeguarding team and the police.

Staff worked with other teams and agencies to promote safety including practices in information sharing. For example, staff worked with schools to ensure the safety of clients' dependent children.

Staff implemented statutory guidance around vulnerable adults and children. Staff were aware of where and how to refer as necessary. The service did not have a designated safeguarding officer onsite. Staff reported to the designated safeguarding officer at the provider's neighbouring hospital, any safeguarding concerns they had. For example, when clients disclosed historical abuse to staff during therapy sessions.

Staff told us children at risk of or suffering significant harm would be identified through the referral and admission process.

Staff access to essential information

Staff kept clients' care and treatment records on an electronic management system and in paper format (prescription charts and physical health observations). All information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it.

Medicines management

Staff followed the provider's medicines management policies in relation to the storage, recording and disposal in line with national guidance. However, staff still had further improvements to make. All clients administered their own medicines at the time of the inspection. Clients kept their own medicines in a locked storage box in their bedroom, which they had the key to. During their first week of admission, staff kept the key to assess the client's ability to take their own medicines safely. Staff responded appropriately when a client needed more support with medicines management. For example, the service's policy stated what staff should do if clients could no longer administer their own medicines. For one client who needed extra prompting and checking, staff carried out daily audits on their medicines to ensure they took them as prescribed.

However, we found that staff did not record that they had checked clients' understanding of their medicines or assessed what the risks might be. The provider had recently completed some improvements in relation to medicines management. This included a new assessment tool that staff completed with clients to assess their ability to administer their own medicines. This had not been implemented at the time of the inspection. Since the inspection, the manager told us they had completed this

new tool for all clients and intended to use it for new admissions to the service going forward. This would allow staff to risk assess clients' safety in respect of self-administration of medicines before admission.

Staff followed the provider's homely remedies policy to ensure the safe management of clients' over the counter medicines. Homely remedies are over the counter medicines made available to people living in residential and nursing care settings or hospitals. They are for short term management of minor ailments, for example, mild pain.

Track record on safety

The service had reported one serious incident in the last 12 months. This involved a client needing an ambulance after they had consumed alcohol.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents on the provider's electronic online system, this then went to the manager for review and approval. Between 13 July 2019 and 9 December 2019, the service had reported 52 incidents. These included safeguarding concerns, security, self-harm, clients using alcohol and illicit substances and medicine incidents.

The service made changes to improve safety and quality of care after incidents. There was evidence that changes had been made because of incidents. For example, the service improved their admission criteria and strengthened their pre-admission screening after a serious incident in January 2019. In addition, the service made the protocol around urine drug screening and breathalysing clients clearer for staff to follow.

Staff were debriefed and received support after an incident. The service also held reflective sessions for all staff to share learning from incidents. Staff discussed incidents in their one-to-one supervision sessions.

Staff received information and learning internally from other services within the organisation. For example, the manager met with the provider's neighbouring other service manager and discussed learning from similar incidents.

The service had a policy on duty of candour and staff knew what it meant. Duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong.

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

Good

Assessment of needs and planning of care

Staff completed a comprehensive assessment of patients in a timely manner at, or soon after, admission. We reviewed three care and treatment records of current clients and five of clients who had been discharged. Staff from the assessment team visited clients before they moved to the service to complete a comprehensive assessment to ensure they were suitable for drug and alcohol rehabilitation.

Assessments included a risk assessment, mental and physical healthcare assessment, GP medical history, medicines history, drug and alcohol use, detoxification summary and social history. The service's senior management and service staff discussed each new client and their needs as a team to ensure the service could meet all the needs of incoming clients.

Staff ensured that any necessary assessment of clients' physical health had been undertaken and that they were aware of and recorded any physical health problems. For example, records demonstrated that all alcohol related risks were assessed including any cognitive impairments clients might have as a result.

Staff developed personalised, holistic and recovery-orientated care plans with clients. Care plans contained specific goals for a client's recovery, which were realistic and detailed. Care plans included improving the client's mental health, assisting clients with debts and financial worries and supporting clients to progress their education. For example, staff had created a goal with a client to use public transport.

Clients met with their designated key worker each week.

Best practice in treatment and care

Good

Substance misuse services

Staff provided a range of treatment and care for clients based on national guidance and best practice. The service provided a 12-step abstinence-based rehabilitation programme for people recovering from drug and alcohol addiction. Clients received a thorough and ongoing assessment of all aspects of the treatment by a multi-disciplinary team, with co-operation between the client and their families.

Staff provided a range of care and treatment interventions suitable for the client group based on national guidance. Staff used cognitive behavioural therapy skills, psychoanalytical approaches and psychodrama to support clients with their recovery. Clients received one-to-one support as well as group work such as life stories and relapse prevention. Clients participated in equine therapy, drama and yoga as part of their recovery.

Staff offered family therapy to clients where appropriate. For example, where clients wanted their family involved, staff set up regular meetings with the family to discuss the clients' care plan and discharge.

Staff supported clients to live healthier lives through participation in health eating awareness, smoking cessation support and dealing with issues relating to substance misuse. Blood borne virus testing was completed by the local GP.

Monitoring and comparing treatment outcomes

Staff regularly reviewed care and recovery plans with clients to ensure they knew that treatment was effective. At the time of the inspection the service had recently introduced a new client outcome measuring tool. This monitored the effectiveness of treatment from the beginning of the clients' treatment to their discharge.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of clients. The team included skilled staff from a range of disciplines including therapists and support workers. The service also had a volunteer peer support worker who attended the service once a week.

The manager identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff had been trained in relapse prevention, harm reduction, family therapy and motivational interviewing.

Managers ensured they followed robust recruitment procedures. For example, we reviewed three staff personnel files and found that each had appropriate checks in place. This included two references from a previous employer to check an employee's experience and skills to carry out their job role. The service had systems in place to check that all staff received a criminal record check. This meant managers knew that staff were suitable to work with clients.

Staff received regular supervision and a yearly appraisal. The manager supervised the therapists and therapists provided supervision to the support workers. In addition, therapists had external group supervision with their registering body.

Multi-disciplinary and inter-agency teamwork

Staff ensured clients' comprehensive assessments included multidisciplinary input from other professionals such as community mental health teams, and children and family services.

Staff held regular multidisciplinary meetings. For example, monthly staff team meetings, group supervision, daily handover and clinical governance meetings. Staff discussed training, incidents, safeguarding and best practice. In addition, staff liaised closely with the provider's neighbouring location's consultant psychiatrist when they needed extra support with a client's mental health. For example, a client attended the provider's other location each week to receive dialectical behavioural therapy and a medication review from the consultant psychiatrist.

Staff discharged clients when they no longer needed drug and alcohol rehabilitation. Staff worked with relevant supporting services to ensure timely transfer of information. For example, staff had started to liaise with a client's family and home community services in preparation for their discharge.

The manager still needed to make further links to improve communication between the service and local health teams. For example, the manager was still developing relations with local GP practices so that new clients could temporarily register with them during their stay. The manager said this remained a challenge and they were holding regular telephone calls to improve this relationship.

Good practice in applying the MCA

Good

Substance misuse services

The service had a policy on the Mental Capacity Act (MCA), which staff could refer to. The service provided training on the MCA and all staff had completed it.

The service did not accept clients who lacked capacity to consent to their admission. However, staff supported clients to make decisions where appropriate and monitored those clients who had fluctuating capacity. For example, staff assumed capacity for all clients. On admission staff commented on whether clients had capacity to consent to admission.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with dignity, respect and compassion. We spoke to two clients currently using the service. Clients said that staff treated them well and they felt safe at the service. Throughout the inspection, staff engaged with clients in a positive and supportive way. Staff provided clients with emotional and practical support. Clients said the service had really helped them with their recovery. Clients specifically told us about staff members who they liked and felt able to talk to openly.

Staff could raise concerns about disrespectful, discriminatory and/or abusive behaviour or attitudes towards clients without fear of the consequences.

Staff supported clients to understand and manage their care and treatment. Staff provided clients with a welcome pack when they arrived at the service. This included the house rules, relapse prevention and local services that clients could access.

Staff maintained the confidentiality of information about clients. Staff gained written consent from each client before sharing any information with other agencies that were involved in their recovery pathway.

Involvement in care

Staff communicated with clients so that they understood their care and treatment. Staff used the admission and referral process to orientate prospective clients to the service. This included, telephone assessments or spending the day at the service before they were admitted. This meant clients could be put at ease.

Staff empowered and supported clients to access advocacy to have their voices heard. Staff displayed leaflets of the local advocacy service in the communal areas. In addition, clients received regular peer support from volunteers who visited the service.

Clients had a recovery and risk management plan in place, which they contributed to. Records showed that staff involved clients in their care. We checked three current care plans and each one showed evidence of the client's voice and their views in their care plans.

Clients could give feedback on the service and their treatment and staff supported them to do this. Community meetings were held weekly, patients told us that they felt listened to and changes were made following the meetings. Clients contributed to the types of activities they would like to participate in as part of their recovery. Clients had regular contact with their key worker to discuss their goals and recovery.

Involvement of families and carers

Staff enabled families and carers to give feedback about the service. The service recognised the importance of family and carer involvement in clients successfully recovering. Families fed back about the service through regular face to face meetings at the service. We spoke to two carers and they felt staff communicated with them well and felt involved in the care of their family member.

Staff engaged with clients and their families to develop responses that met their needs. Staff held regular joint meetings with the client and their families to discuss and plan their care and treatment.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

Good

Substance misuse services

The service had a clear referral system in place for people whose needs they could not meet. Staff followed the service's admission criteria when accepting new referrals. Staff required clients to have been through a detoxification and be committed to not taking drugs or consuming alcohol for the duration of treatment. Staff received referrals from the provider's neighbouring inpatient detoxification service and another rehabilitation service overseas.

Managers assessed applicants' suitability at a pre-admission interview. The service did not accept applications from people who were unable to manage their medication, people who found it difficult to manage their behaviour and people whose physical health meant they would be unable to leave the building in an emergency unaided.

The service was not full at the time of the inspection and there was no waiting list. The aim was that clients would stay for a minimum of 28 days and then up to 12 weeks if needed. Since the service opened in October 2018, most clients completed the treatment programme within 12 weeks with only one client taking 15 weeks to complete the programme.

Staff planned for clients' discharges. Clients' recovery plans included the complex needs of the clients and plans for discharge. For example, one client's records showed that staff had liaised with their family and crisis team in readiness for a phased discharge.

A weekly aftercare group was held for clients who had been discharged. These clients were encouraged to attend the sessions. In addition, staff held annual events celebrating clients' recovery as well as celebrating seasonal holidays. At the time of the inspection, staff were planning their Christmas celebrations, which they anticipated previous clients would attend.

Staff supported clients during referrals and transfers between other services. For example, if clients were transferred to a mental health hospital, a staff member would support them by escorting them to the site.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had their own bedrooms and were not expected to share. Clients could personalise their bedrooms. Clients had a secure storage area in their bedroom where they could keep their possessions securely. Each client had lockable storage in their room where they could store their medicines. In addition, all bedrooms were fitted with locks.

Clients had access to a full range of rooms to support the therapeutic environment. This included two lounge areas, a spacious kitchen and garden

Clients could make a phone call in private. Clients used their mobile phones outside of group therapy.

Clients accessed a spacious garden for fresh air. The service had created a designated smoking area for clients to use. Smoking was not allowed inside. The provider planned to implement a smoke free policy at the service to align with the rest of the provider's services.

Clients said they enjoyed the food and it was of good quality. Clients took part in cooking their own meals and snacks when they wanted. Clients prepared meals for the rest of the group as part of the recovery programme. This meant that clients chose their meals and snacks.

Patients' engagement with the wider community

The service encouraged clients to access education and work opportunities. Some clients were supported with maintaining their employment as part of the aftercare programme. Staff encouraged clients with social activities. For example, some clients attended a local gym. The service also arranged social activities, such as trips to the local cinema and outdoor assault courses.

Staff tried to encourage clients to develop and maintain relationships with people that mattered, for example family members. Staff actively involved family members in clients' care and treatment where appropriate. Clients could use tablet devices to keep in touch with their family at longer distances. For example, for those family members that lived outside of London, staff kept in touch over the telephone. Staff took steps to ensure the service was clearly open and inclusive for lesbian, gay, bisexual and transgender plus (LGBT+) clients. For example, in group therapy and through the admission process.

Meeting the needs of all people who use the service

The service made suitable adjustments for patients with disabilities to access the premises. The service refurbished a bedroom to ensure it could be easily accessed for clients with low mobility.

Good

Substance misuse services

Staff supported clients with protected characteristics and ensured they were an inclusive service. There were local links with support groups that were specific to their needs. For example, clients could access fellowship meetings in the community for lesbian, gay, bi-sexual or transgender people.

Staff ensured patients obtained information on substance misuse, how to complain, local services and treatments available through a welcome information leaflet.

Staff provided treatment and information in the English language. However, for patients whose first language was not English staff would provide interpreters or source information available in other languages.

Patients had a variety of meal choices that supported their dietary requirements. This included foods to meet patients' individual religious needs such as halal or kosher foods. Staff supported clients with weekly food shopping and prepared meals that clients cooked together or with staff. This meant the choices of meals and snacks was based on individual preferences.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the outcomes. Since 1 January 2019 the service had received seven complaints from clients and carers. Patients complained about agency staff and miscommunication.

Patients knew how to complain and felt able to do so. Staff displayed this information on the noticeboards in communal areas.

When patients complained, staff provided them with feedback from investigations. For example, the manager wrote to the client and verbally discussed the outcome with them. We looked at one complaint received, which showed that clients received support from staff in a timely way after they complained. In addition, staff acted on complaints to make improvements to the service. For example, the manager changed therapists around when a client complained that they did not have a female therapist.

Managers handled complaints appropriately. The managers kept a log of all formal and informal complaints. The managers discussed complaints with staff at their monthly team meetings and shared any learning that had resulted.

The service received compliments. Some compliments were displayed on notice boards within the communal areas.

Are substance misuse services well-led?

Requires improvement

Leadership

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

Staff and patients said they knew who the senior staff team were and that they were approachable. The senior team were visible at the service and had regular contact with clients. The operations manager and health and safety managers visited the service regularly.

The service encouraged leadership development including opportunities for staff below team manager level.

Vision and strategy

The service had a clear vision and strategy that all staff understood and put into practice. The provider aimed to provide a safe setting to enable clients to focus on continued recovery. Staff emphasised optimism in clients' recovery and treated them with dignity and respect.

Staff had the opportunity to contribute to discussions about the strategy for the service. For example, staff suggested ideas about how the service could improve and better ways of working during their clinical governance meetings, whilst ensuring they were fulfilling the ethos of the service.

Staff explained how they worked to deliver high quality care within the service's financial means.

Culture

Staff felt respected, supported and valued by their team and the provider. They said they were proud to work in the service and working relationships were friendly and positive. Staff said they would have no hesitation in raising any concerns about the service.

Staff told us they considered there was equality of opportunity but due to the service being small, staff did not have many opportunities for progression in the service. This meant that staff turnover was higher with five staff members out of 10 leaving the service in the last 12 months.

The manager could access support from the provider to manage any areas of poor staff performance.

The service's staff sickness was above the average for the provider. At 11 September 2019 the service recorded a staff sickness rate of 5%.

Governance

The provider ensured there were structures, processes and systems of accountability for the performance of the service. The manager from the service and the provider's nearby location met up regularly to discuss performance and similar practices. Staff held monthly clinical governance meetings and discussed pertinent issues such as incidents, staffing, feedback from patients and performance of the service. This system ensured key messages and learning were communicated from service level to the provider and vice versa.

Staff did not always make notifications to the Care Quality Commission as required. Between 01 January 2019 and 10 December 2019, we found two incidents of allegations of abuse in relation to clients and one incident of serious injury that were not reported to the Care Quality Commission. The service is required to notify the commission of any allegations of abuse in relation to a service user but had failed to do so on these occasions. The manager explained this was an oversight and submitted the relevant notifications immediately after the inspection. The service had referred these allegations to the local safeguarding team.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. The service had a serious incident in January 2019. A senior manager investigated this, made recommendations and staff implemented the actions.

Senior managers monitored the effectiveness and performance of the service. Staff carried out local clinical audits to monitor effectiveness. Staff completed audits to provide assurance on issues such as infection prevention and control and therapeutic group work. In addition, the service recently completed an internal quality review prior to the inspection. This was an internal inspection, carried out by a senior manager from one of the provider's other services. We looked at the results for the most recent one completed in April 2019. It showed similar areas for improvement that we identified during the inspection. For example, completing a risk assessment for clients to ensure they were able to self-administer their own medicines safely. Another recommendation was for staff to ensure they completed weekly checks of the automated defibrillator (AED) to ensure it worked. We found staff recorded weekly checks of the AED and made sure it was fit for purpose.

Management of risk, issues and performance

Senior managers used systems to identify, understand, monitor, and reduce or eliminate risks that were mostly effective. They ensured risks were dealt with at the appropriate level. The service had a local risk register, which the manager added to when needed. Risks included staffing levels and lone working. The manager said a business case had been put forward to increase staffing levels at night.

The service had plans for emergencies. Business continuity plans covered a range of scenarios such as a terrorist bomb threat.

Information management

Staff said they had access to up to date information from the provider. Staff had received training on data security and confidentiality. The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The manager had access to pertinent data about the service, for example, discharges and length of client admissions.

The information systems were integrated and secure. Information was recorded in a combination of an electronic record system and paper records. Staff completed incident records on the provider's electronic system.

Engagement

Good

Substance misuse services

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services. The service was small, but part of a wider organisation. Clients could learn about the provider's other services through newsletters and staff. Staff met with clients in the morning planning meetings and discussed any updates at service level.

Patients and carers had opportunities to give feedback on the service. Clients gave staff feedback in weekly community meetings and on the service's 'you said, we did' boards.

Clients and carers were involved in decision-making about changes to the service. For example, clients had been involved in recruitment panels to interview prospective new staff.

The service collaborated with partner organisations to help improve services for patients. This included community mental health teams and social workers. This ensured that staff worked with others to ensure consistent care and treatment for clients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the service sends all required statutory notifications to the Care Quality Commission without delay. **Regulation 18(2)(e) (Registration) Regulations.**

Action the provider SHOULD take to improve

- The provider should ensure they review the overall risks relating to their client group, such as risk of overdose from illicit substances and the need to have access to naloxone. The provider should then take appropriate action to acknowledge and mitigate these risks.
- The provider should consider implementing individual early exit plans for all clients.
- The provider should continue to embed their risk assessment of the client's ability and competence to understand and safely administer their own medicines.
- The provider should ensure staff keep accurate cleaning records in relation to the premises.
- The provider should ensure they clearly record when they have checked the lint in the tumble dryer machine to ensure it is adequately and safely maintained.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents