Sanctuary Banbury Limited

Banbury Lodge

Inspection report

The Hawthorns
Banbury
OX16 9FA
Tel:

Date of inspection visit: 15 September 2022
Date of publication: 21/12/2022

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?	Good
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

Our rating of this location stayed the same. We rated it as good because:

- The service provided safe care. The premises were safe and clinical areas were clean. The service had enough staff. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatment and therapy suitable to the needs of the clients and in line with national guidance and best practice.
- The team had access to specialists required to meet the needs of clients under their care. Managers ensured staff received training, supervision, and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated clients with compassion and kindness and understood individual needs. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative referral pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

However:

- Shortages in housekeeping staff meant non-clinical areas were not always cleaned to a high standard.
- Medicines management process improvements needed further embedding.
- The provider's strict focus on maintaining COVID-19 isolation measures resulted in multiple complaints, staff anxiety, a lack of medical presence, and lengthy isolation periods for clients in which they experienced segregation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	Our rating of this service stayed the same. We rated it as good. See the above summary for details. We rated this service as good because it was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Summary of this inspection

Background to Banbury Lodge

Banbury Lodge is operated by Sanctuary Banbury Limited. It registered with CQC in September 2017 and opened in April 2018. It is a 23-bed residential unit providing detoxification and rehabilitation programmes to clients over the age of 16 with substance misuse needs, including alcohol and/or opiate dependency. The service also provides care for clients with gambling addiction and eating disorders. Admissions vary based on client need and range from two weeks to three months.

The residential service uses a medically monitored detox model that provides a programme of psychological interventions focused on positive behaviour change, thinking, and emotional response. The service provides care for clients who do not require 24-hour medical intervention, can self-care, and have full mental capacity.

Banbury Lodge is registered to provide:

- Accommodation for clients who require treatment for substance misuse and treatment of disease, disorder or injury.

A new manager had recently joined the service and was completing their registration process with us. This was completed after our inspection.

We lasted inspected the service in February 2019 and rated it good.

What people who use the service say

All the clients we spoke with were positive about their care and support. They appreciated the dedication of staff, the range of therapeutic activities, and the high quality and choice of food. Clients felt staff were genuinely caring and attentive.

How we carried out this inspection

We carried out an unannounced inspection of the service on 15 September 2022 using our comprehensive methodology. Our inspection team comprised a lead inspector and a specialist advisor who was a registered mental health nurse (RMN). During our inspection we visited all areas of the building, spoke with staff across all teams, and observed care being delivered. We reviewed 11 care plans, reviewed medicine management charts, and other documentation relevant to the inspection framework. After our inspection we carried out a remote interview with a senior member of staff who was unavailable on the day of our inspection. The provider submitted 100 items of evidence after our site visit, which we used as evidence for our report and ratings.

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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.

Summary of this inspection

Action the service SHOULD take to improve:

- The service should ensure clinical supervision is structured and documented.
- The service should ensure improvements to medicine management processes continue to be embedded in the service.
- The service should consider how learning from complaints is reflected in practice.
- The service should consider updating its COVID-19 protection policy in line with NHS England guidance.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Substance misuse services

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

Are Substance misuse services safe?

Good

Our rating of safe stayed the same. We rated it as good.

Safe and clean care environments

All clinical premises where clients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Communal areas were not always kept clean.

Safety of the facility layout

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced risks they identified. They adapted risk assessments for changes in the building or work processes and to meet individual client needs. For example, staff used risk assessments for clients at risk of self-harm to ensure they were kept safe.

Therapists ensured group meeting areas were safely organised.

Staff knew about any potential ligature anchor points and mitigated the risks to keep clients safe.

Staff had easy access to alarms and clients had easy access to call systems. Staff used a central operations room to coordinate any emergency response.

The senior team carried out regular fire drills and maintained records of fire system maintenance and checks. Staff had completed fire marshal training and allocated a named fire marshal at each handover.

Staff completed personal emergency evacuation plans (PEEP) for clients with reduced mobility. This was collaborative and staff demonstrated the emergency procedures and escape routes to clients on admission. Each client with a PEEP in place had a named member of staff on each shift who would support them in the event of an evacuation.

Maintenance, cleanliness and infection control

Good

Substance misuse services

Most areas were clean, well maintained, suitably furnished, and fit for purpose. The centre was located amongst woodland and windows in some communal areas were susceptible to cobwebs and natural debris. One housekeeper worked in the service full time and an agency housekeeper provided support. The service was recruiting for a second full time, permanent housekeeper.

The catering team were responsible for cleaning and infection control in the kitchen and food storage areas. While these areas were visibly clean during our inspection, there was room for improvement in how the kitchen space was managed to ensure good hygiene standards. For example, a table area was used for staff personal items adjacent to food preparation and the dishwashing area was not fully sterile.

Staff made sure cleaning records were up-to-date for clinical areas. Clients contributed to cleaning communal areas on a rota basis.

Staff followed infection control policy, including handwashing. All staff were required to sign a daily log of hand hygiene compliance. The registered manager monitored this to document assurance of consistent practice, although this was not supplemented with formal observational audits.

Clinic room and equipment

The service had accessible resuscitation equipment and emergency drugs that staff checked regularly. Oxygen and an automatic external defibrillator (AED) were stored on site and staff were trained in using them. Staff had access to a breathalyser, a blood pressure monitor, and a blood oxygen device.

Staff checked, maintained, and cleaned equipment. The provider had a planned preventative maintenance programme in place for clinical equipment, including breathalysers.

Safe staffing

The service had enough nursing and medical staff, who knew the clients and received basic training to keep people safe from avoidable harm.

Nursing and support staff

The service had enough nursing and support staff to keep clients safe. Staffing levels per shift were fixed and did not change based on occupancy. One registered nurse worked in the service Monday to Friday. Five therapists and seven support workers, including senior therapists and senior support workers, worked in the service. Dedicated administrators, housekeepers, catering staff, and maintenance staff were based on site.

Overnight, two support workers were based in the service and an on-call senior manager provided support.

The service had reducing vacancy rates. Two new recovery support workers had recently joined the service, which reduced the reliance on agency staff. The service was recruiting for one permanent waking night support worker and additional bank recovery support workers.

Levels of sickness were low. The service did not formally track levels of staff sickness although there had been no interruption to care in the previous 12 months caused by short staffing.

The service had reduced the rates of agency staff and long-term bank staff supported consistent staffing.

The registered manager made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health. Staff said they felt the new registered manager cared about their welfare and supported them to achieve a good work/life balance.

Clients had a 50-minute one-to-one session with their named therapist. Clients could increase the number of sessions in discussion with their therapist. The nurse provided a daily 30-minute drop-in service for clients with any medical needs.

Staff shared key information to keep clients safe when handing over their care to others. Three formal handovers took place daily, which included key information on client need and risk management.

Medical staff

There was no on-site medical cover in the service. Three psychiatrists were based off site and completed remote pre-admissions assessments before a client could move into the service, followed by a treatment plan. They monitored patients at key stages of care as part of the medically monitored detox model.

The three consultants were based substantively in NHS services and provided care through a self-employed contract with this provider. The consultants had provided fully remote care and review since the beginning of the pandemic and said there was no plan to resume in-person services.

Mandatory training

Staff completed and kept up-to-date with their mandatory training. At the time of our inspection, compliance was 99%.

The mandatory training programme was comprehensive and met the needs of clients and staff. It reflected the holistic nature of care and included topics such as stress management, supporting good sleep, and managing panic attacks. All staff completed a set of modules that included topics such as safeguarding, infection prevention and control, and health and safety. Staff completed other modules based on their specific role. All staff involved in client care held completed the national care certificate.

The provider updated mandatory training requirements periodically to reflect new standards of practice and learning. For example, in 2021 staff completed new training on motivational interviewing and the context of professional boundaries.

Managers monitored mandatory training and alerted staff when they needed to update their training. The registered manager ensured staff had protected time for training.

Staff spoke positively about the standard of training although noted this was fully delivered online and hoped the provider would resume pre-COVID-19 practical training soon.

Assessing and managing risk to clients and staff

Good

Substance misuse services

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. They responded promptly to sudden deterioration in clients' physical and mental health.

Assessment of client risk

Staff completed risk assessments for each client before and after admission, and at key stages in the treatment pathway. They used recognised tools to monitor level of risk and need, and reviewed these regularly, including after any incident. The service provided care and support to clients who could self-care who were at the same level of risk as those who received home support community detox.

Staff used a specific risk assessment process for adolescent clients. This included involvement from the individual's parents at the pre-admission stage and at key stages during treatment.

Staff assessed the level of dependency on substances, such as alcohol or opiates, at the pre-admission stage and included these in care plans. There were clear limits to the level of care the service could safely provide and consultants referred clients to other services in such cases.

Clients could use the gym on site on completion of a doctor's risk assessment. This was typically after the first few days of detox when mobility and coordination stabilised.

Management of client risk

Staff knew about any risks to each client and acted to prevent or reduce risks. Pre-admission risk assessments were comprehensive and included discussions of past medical and mental health needs. This process depended on clients to provide truthful, accurate information where they declined access to GP records.

Staff identified and responded to any changes in risks to, or posed by, clients. A doctor was on call 24-hours, seven days a week and the registered nurse provided clinical oversight during weekdays.

Staff followed procedures to minimise risks where they could not easily observe clients. For example, adolescents were accommodated in a separate area to adults and staff controlled access between areas.

Staff followed the organisation's policies and procedures when they needed to search client bedrooms to keep them safe from harm. Clients signed a contract at the point of admission as part of their detox care plan. This meant they were not permitted to keep mobile phones or laptops with them and could only access such equipment at specific times, as part of the programme structure.

Staff carried out hourly observations within the first 24 hours of admission for adolescent clients and increased this to continuous observations if there were increased risks. Staff carried out welfare checks every 2.5 hours between 7am and 11pm.

The service did not have a written protocol for the threshold of risk. The nurse or a support worker reported client observations to remote doctors as needed and the doctors made decisions about prescribing or care escalation. Nurses and support workers could increase the level of support for clients independently, without medical practitioner input, when they identified an immediate risk.

Staff were trained to support clients at risk of, or with current practices relating to, self-harm. They worked with clients to reduce risk and promoted safer techniques as part of a harm reduction strategy.

Use of restrictive interventions

The service did not admit clients with known risks of violence or aggression or those who needed seclusion. Staff did not restrain clients and used de-escalation techniques to help clients if they became agitated.

Clients under the age of 18 were segregated from adults in line with the provider's policy. Adolescents mixed with other clients during the programme day and group sessions. The service had three dedicated bedrooms for adolescents and staff increased supervision when they were occupied. Parents or the client's responsible adult completed a pre-admission accompanied visit and accompanied the client during admission. This was part of the provider's policy to ensure segregation was safe and appropriate.

The provider maintained strict COVID-19 testing protocols. Clients were required to self-isolate in their bedroom for the first four days of admission. If a patient wished to go outside to smoke, staff issued them with a radio so they could check no-one else was in the area. Staff made some exceptions for clients admitted for eating disorder rehabilitation, such as being allowed to eat with other clients communally. This was time limited and they were required to return to isolation immediately after their meal. After our inspection the provider told us this system was in place due to the high levels of vulnerability amongst clients and staff.

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 knew how to apply it.

Staff received training on how to recognise and report abuse appropriate for their role. All staff were trained to safeguarding level two and clinical and therapy staff were trained to safeguarding level three.

Staff were kept up-to-date with their safeguarding training and had access to regular updates from the provider. External agencies provided supplementary training, such as recognising coercion amongst women experiencing addiction.

Staff could give clear examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act. They worked with external organisations to ensure clients with needs relating to gender identity and sexual identity were appropriately supported.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. They used referral procedures when clients disclosed details of safeguarding risk to others, including people outside of the service.

The service had a safeguarding log available to all staff. The team used this to document concerns or referrals. The named provider safeguarding lead was readily contactable. Each shift had a designated safeguarding lead and staff allocated this role during handovers.

Staff had made appropriate contact with safeguarding teams and the police when clients disclosed criminal behaviour such as sexual assault.

Good

Substance misuse services

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.

Client notes were comprehensive, and all staff could access them easily. The service used an electronic system that meant all records relating to each client were available at a single point of access. Doctors accessed the electronic system remotely to carry out assessments and reviews.

When clients transferred to a new team, there were no delays in staff accessing their records. Staff shared records only with client consent, such as with their GP on discharge, or where the safety of another person was at risk, such as with the police.

The induction for bank and agency staff included use of the electronic records system and had the same level of access as permanent staff.

The electronic system was encrypted, and access was traceable to authorised staff only.

Medicines management

The service used systems and processes to prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's mental and physical health.

Staff followed the provider's systems and processes to store, prescribe, and administer medicines. Doctors prescribed medicines based on individual treatment plans for the course of each client's admission. They prescribed ad-hoc medicines remotely based on medical assessments completed by the nurse and the care team.

Staff reviewed each client's medicines regularly and provided advice to clients and carers about their medicines. Doctors used a remote prescribing system connected to an electronic medicines management system in the service.

Staff stored all medicines, including Controlled Drugs (CDs), safely. The provider had a named responsible officer for CDs in line with national guidance and local practices reflected Home Office requirements. Staff audited CDs twice weekly.

Staff followed national practice to check clients had the correct medicines when they were admitted, or they moved between services. Doctors liaised with other health professionals involved in clients' care to ensure prescribing was coordinated, safe, and in line with National Institute for Health and Care Excellence (NICE) guidance. They assessed medicines risk in line with the government's Orange Book guidance.

Staff learned from incidents to improve practice. Medicine audits found a series of 31 medicine documentation errors between August 2022 and September 2022. They investigated each instance with the team and implemented a new electronic management system to improve safety practice. At the time of our inspection the new system had not yet had time to demonstrate if it contributed to reduced errors. Staff told us they felt more confident in using the new system and said it had reduced opportunities for risk.

Support workers completed medicines management competency training that enabled them to administer and document medicines.

Good

Substance misuse services

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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.

Staff knew what incidents, including serious incidents and near misses, to report and how to report them in line with provider policy.

Staff understood the duty of candour. They were open and transparent and gave clients and families a full explanation if things went wrong. The provider had a threshold to trigger the duty of candour and the registered manager would usually lead this.

Managers debriefed and supported staff after any serious incident. This was a key area of improvement implemented by the new registered manager, who focused on ensuring staff always had the opportunity to discuss incidents before leaving their shift.

Managers investigated incidents thoroughly. Clients and their families were involved in these investigations and the outcomes led to better practice.

Staff received feedback from investigation of incidents, both internal and external to the service. The operations managers shared learning from across the provider's services with staff monthly.

Are Substance misuse services effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

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 completed a comprehensive mental health and physical health assessments of each client on admission and regularly reviewed these during their programme. Doctors relied on GPs, including private GPs, to provide medical histories in advance of an admission, as well as blood test results. However, this was not mandatory, and doctors sometimes admitted clients based on their own account of their health and needs. In such cases the admitting doctor used a 'dynamic risk assessment' in place of a medical history to help staff track health changes and needs and ensure treatment was safe.

Doctors required clients with very low body mass index (BMI) of under 16 to undergo blood tests ahead of admission to check for potassium levels and vitamin deficiencies. If the client was cognitively impaired as a result of malnutrition, doctors established thresholds for admission if the client was able to gain weight and strength.

Staff developed a comprehensive care plan for each client that met their mental and physical health needs. They used a system of continual needs assessment and progress to plan as clients progressed through their individual programme. The provider named this a 'golden thread', which reflected staff focus on clients' key needs. Care plans were client-centred, and staff took time to link needs and challenges to support successful outcomes.

Staff regularly reviewed and updated care plans when clients' needs changed. This included at key stages of the detox programme or when the client reported unexpected symptoms or health changes.

Care plans were personalised, holistic and recovery-orientated. It was evident staff took time to get to know people and understood their goals and challenges.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance. They ensured clients had good access to physical healthcare and supported clients to live healthier lives. Staff used recognised rating scales to assess and record outcomes.

All staff could access policies and procedures online and the provider's compliance team ensured they were up to date.

Staff provided a range of care and treatment suitable for clients in the service, in line with best practice and national guidance from relevant bodies such as the National Institute for Health and Care Excellence, the Royal College of Psychiatrists, the British Association for Counselling and Psychotherapy (BACP), and Developing Health & Independence.

Staff identified clients' physical health needs and recorded them in their care plans and made sure clients had access to physical health care, including specialists as required.

Staff met clients' dietary needs and assessed those needing specialist care for nutrition and hydration. The head chef took a lead role in planning menus and nutrition that met individual needs. They reviewed known dietary needs in advance of new client admissions and planned meals and snacks collaboratively with care staff. The head chef had introduced improved catering systems. This included new professional equipment to keep food fresh. They had removed frozen meat and vegetable products from the service in lieu of a focus on fresh items.

Staff helped clients live healthier lives by supporting them to take part in programmes or giving advice. Programmes were therapeutic by nature and aimed to improve mental and physical health on a staged basis as clients progressed through detox.

Staff used recognised rating scales to assess and record the severity of clients' conditions and care and treatment outcomes. This process was based on national guidance, including the Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) and the clinical opiate withdrawal scale (COWA). Staff completed a CIWA-AR score four times daily.

Good

Substance misuse services

The provider measured client outcomes on an on-going basis. In the previous 18 months, 85% of clients said they had remained sober since completing their programme and 75% said they were engaged in post-discharge support.

Skilled staff to deliver care

Teams included or had access to the specialists required to meet the needs of clients under their care. Managers made sure staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Each team involved in delivering care, support, and treatment, specialised in key areas. Therapists specialised in different types of detox and recovery, including addiction and eating disorders, which reflected the range of care available in the service. An eating disorder specialist had complete training with the National Centre for Eating Disorders and was an accredited master practitioner of eating disorders and obesity in systemic therapy. Where medical or psychiatric specialists were needed, staff referred clients externally.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the clients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. The provider obtained the annual appraisal of each doctor who provided remote client assessments from their NHS responsible officer. This provided assurance their practice and track record remained appropriate for this service.

Managers supported staff through regular, constructive supervision of their work. At the time of our inspection, all staff were up to date with their supervision plan. Therapists had monthly supervision and some of the team paid out of pocket for their own private clinical supervision that followed BACP guidance. The team held monthly group supervisions and individually had a monthly supervision from their line manager.

The nurse had completed clinical supervision within the last 12 months with the provider's clinical lead, but this had not been documented and we were not assured it was structured or fit for purpose.

Managers supported staff to develop their skills and knowledge and gave them the time and opportunity for specialist training. For example, therapists had recently completed dialectical behaviour therapy training (DBT) and trauma training. The senior therapist was trained in eye movement desensitisation and reprocessing and was a qualified integrative addiction therapist. The provider supported staff to complete higher education courses, including degrees.

Multi-disciplinary and interagency teamwork

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. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

All aspects of care were demonstrably multidisciplinary. This process began with the pre-admission process that was led by a doctor with input and review by the therapy team and nurse. At the point of admission, key staff met to plan

care based on the clients' needs. For example, a dietician met the head chef and care team to plan nutrition and hydration for each clients' programme. Other allied health professionals, such as nutritionists and physiotherapists, were involved on request. Staff said this reflected the significant change in needs and individual preferences at the beginning of treatment compared to the end.

Staff held monthly multidisciplinary meetings to discuss clients and improve their care. The team supplemented the formal meeting with individual multidisciplinary reviews for each client as needed. The provider encouraged staff to learn from colleagues in other services in their network. A senior support worker had visited another service to observe and learn from new initiatives.

Staff made sure they shared clear information about clients and any changes in their care, including during handover meetings. Staff made sure they shared clear information about clients and any changes in their care, including during handover meetings. Handovers took place three times daily at each shift change. We reviewed a sample of seven handover records and found staff were client-focused in their approach. They documented needs holistically.

The head chef had introduced new client handover sheets for the catering team. This included each client's allergens, dietary needs, and preferences needed for daily meal preparation.

Support and therapy teams had effective working relationships with each other and with other colleagues in the service.

Staff developing good working relationships with social services teams and involved them where clients had children or vulnerable relatives at home. Most clients did not live in the local area and staff established contact details for each client's local authority on admission.

The service was in the process of establishing a working relationship with the local probation team in recognition of increased demand for services from prison leavers.

Staff had developed links with specialist non-profit recovery organisations and provided space for them to deliver weekly sessions with clients in a dedicated external building. This enabled clients to benefit from a range of specialist organisations and input into their detox and rehabilitation.

Good practice in applying the Mental Capacity Act

Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and established capacity before admission.

The service provided care for clients who could consent to treatment. Where clients had partial capacity, doctors prepared specific care plans for them. For example, clients could complete a physical detox in the service and then be discharged to a more specialist service for ongoing rehabilitation.

Staff were up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards (DoLS), which staff could describe and knew how to access. If a client required a DoLS authorisation for safe care, the service referred them to a more appropriate provider.

Good

Substance misuse services

Staff assessed and recorded capacity to consent each time a client needed to make an important decision. They discussed information sharing with each client at the point of admission, such as for sharing treatment information with their GP. The detox programme was designed to involve clients' families and staff established consent at the beginning of treatment to contact and share information with family members as each client deemed appropriate.

Are Substance misuse services caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

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

Staff were discreet, respectful, and responsive when caring for clients. We observed genuinely kind interactions between staff and clients during our inspection. Clients said staff treated them well and behaved kindly. One client said, "The quality of the input from therapists is what really stands out." Another person said, "Therapy and staff support is better than other place I've been."

Staff gave clients help, emotional support and advice when they needed it. Clients we spoke with offered personal accounts of their experiences with staff and said they provided emotional support that was compassionate and meaningful.

Staff supported clients to understand and manage their own care treatment or condition. The admission process included discussions of care planning with each client and staff explained to clients the importance of each stage of treatment.

Staff directed clients to other services and supported them to access those services if they needed help. This included non-clinical services where they needed support with other aspects of their lives, such as housing associations and financial institutions.

Staff understood and respected the individual needs of each client and provided care and support in line with the provider's code of practice for drug and alcohol professionals. This was displayed around the building as part of an approach to ensure clients understood the nature of their care and the services offered.

Staff felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards clients. This was part of the provider's whistleblowing policy and staff said they felt confident their line manager, or the senior provider team would act on reports.

Staff followed policy to keep client information confidential. Where clients did not want their GP, or family, involved in their care, staff respected their decisions. They worked with clients to get the most out of the programme.

Clients described acts of kindness from staff and said they felt respected and safe.

Good

Substance misuse services

Involvement in care

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.

Involvement of clients

Staff introduced clients to the service and the building's facilities as part of their admission.

Staff involved clients and gave them access to their care planning and risk assessments. Clients detoxifying from opiate use could choose their preferred treatment method between dihydrocodeine or methadone. The admitting doctor worked with each individual to make the most appropriate choice for them.

Staff made sure clients understood their care and treatment and found ways to communicate with clients who had communication difficulties. They used adapted communication resource for clients with symptoms of Korsakoff syndrome, including memory cards and visual prompts.

Staff involved clients in decisions about the service, when appropriate, and could give feedback. Clients attended a weekly community meeting in which they could give feedback about all aspects of the service and make requests and suggestions. Staff reviewed requests and updated clients each week on progress. Staff facilitated the community groups as safe spaces to talk and clients could contribute through anonymous written requests outside of the formal session. Clients spoke positively about this process and told us it was an effective way to request items that made their stay more comfortable, such as the supply of different condiments and juices at mealtimes.

Where clients disclosed a history of, or intent to, self-harm, therapists worked with them to establish a self-harm contract. This established the expectations of staff regarding the client's behaviour and their ability to ask for help.

Staff made sure clients could access advocacy services. Information on regional specialist services were displayed around the lodge and clients could contact them during their stay. Conversations between clients and advocates were confidential and the service did not monitor or track contacts and engagement.

Clients were involved in all levels of the service. Each new client was paired with a peer support person. This was someone who was settled in the service and understood the meetings, opportunities, and rules. Other systems for involvement included peer of the week and weekly house leaders.

Involvement of families

Staff informed and involved families and carers appropriately.

Staff supported, informed, and involved families. Family involvement in recovering from addiction was embedded in the programme. Staff worked with families to involve them at key stages of recovery and therapy and in structured meetings to help agree on the client's boundaries after the left the service. Families had access to group support facilitated by the service for up to 12 months after the end of treatment.

Staff provided updates to families if clients consented to this. While they communicated as often as needed with relatives, the service remained closed to visitors as part of the provider's COVID-19 measures.

Good

Substance misuse services

Are Substance misuse services responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.

Bed management

Doctors used admission criteria to decide if the service could provide appropriate care for clients. Those with compromised liver function, psychosis, a history of falls, poor nutrition, and a history of seizures were referred to more appropriate facilities.

The service operated continually at 100% occupancy. At the time of our inspection 50 clients were on a waiting list for admission.

Doctors and the senior team regularly reviewed length of stay for clients to ensure they did not stay longer than they needed to. A planned discharge was established at the point of admission based on the type and complexity of detoxification needed. This typically ranged from two weeks to three months. Senior staff said the decision to extend a length of stay was made jointly between a doctor and the client.

A centralised admissions team triaged referral and coordinated the admissions process.

Most clients came from outside of the local area and the admissions team coordinated access with GPs and other professionals who provided care.

Managers and staff worked to make sure they did not discharge clients before they were ready. While doctors made recommendations at the end of the planned programme, the client made the final decision about discharge based on their needs and ability to pay for extended detox.

Discharge and transfers of care

Managers monitored the number of clients who self-discharged before the end of their programme and worked to reduce these.

Staff carefully planned clients' discharge and worked with the wider health team to make sure this went well. Each client decided how a successful discharge would look for them and worked with the admitting doctor and service team to plan this.

Good

Substance misuse services

Staff supported clients when they were referred or transferred between services. Incident reports reflected good working practices when clients required more advanced medical detoxification care or where their mental health deteriorated beyond the capacity of the service. Staff escalated care appropriately and worked with other providers and clients to ensure they received the most appropriate treatment.

The registered manager was working with staff to improve processes around supporting clients who said they wished to self-discharge, to support completion of their programme. This followed a series of instances of clients self-discharging.

Staff provided clients with copies of their care plan and discharge summary at the point of discharge. They provided copies to the client's GP or other health professionals on request.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the service 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 and outdoor areas for fresh air.

Each client had their own bedroom, which they could personalise. Clients could request rooms in specific parts of the building and staff worked with them to manage preferences.

Clients had a secure place to store personal possessions. Staff provided separate, managed storage for electronic devices.

The service had a range of rooms and equipment to support treatment and care. This included quiet spaces, group therapy spaces, and a clinic room for nurse consultations.

Clients could make phone calls in private at designated times. Staff managed this in line with each client's approved detox programme.

The service had outside spaces that clients could access easily. These included picnic benches, a garden, and a conservatory. A purpose-built meeting pod was located separate to the main building and was used for community meetings with groups such as Alcoholics Anonymous.

Clients could make their own hot drinks and snacks any time of day or night and were not dependent on staff.

There was a good range of therapy activities within care programmes. Staff organised yoga sessions, music therapy sessions, and daily client walks. Staff were in the process of creating a sensory and music room. The gardener was creating a vegetable patch that clients could contribute to and the service had invested in new garden furniture. At weekends staff focused on a less intensive, more creative approach.

Meeting the needs of all people who use the service

The service met the needs of all clients, including those with a protected characteristic or with communication needs.

The service could support and make adjustments for people with mobility needs and those with communication needs or other specific needs. The team had completed training in delivering services to people living with learning disabilities and autism in line with the recommendations of the All Party Parliamentary Group on Autism, the National Autistic Society, and the National Institute for Health and Care Excellence.

Staff designed therapeutic groups to reflect the diversity of clients. These included sharing life stories, meditation, sound therapy, and a combination of one to one and group sessions.

Staff made sure clients could access information on treatment, local services, their rights and how to complain. This information was posted around the building and in the information given to clients at the point of admission.

Staff arranged translators for clients as needed. This was identified at the pre-assessment stage and staff made arrangements in advance.

The service provided a variety of food to meet the dietary and cultural needs of individual clients. The head chef planned and prepared meals for clients with eating disorders as well as for those who had religious or cultural needs and who were vegetarian or vegan.

Staff recognised the importance of accommodating clients' food and drink preferences. Fresh fruit and a range of appropriate snacks were available 24/7. The head chef said they coordinated menus and food to reflect clients' own habits at home.

Adolescents received enhanced one-to-one therapy support, with twice-weekly sessions instead of one. This was supplemented with a weekly family session to support good communication and relationships between young addicts and their family.

The provider maintained strict COVID-19 prevention protocols, which meant clients spent a minimum of four days after admission in isolation. They were unable to meet other clients or socialise during mealtimes and the provider required them to eat alone in their bedrooms. This reduced client access to therapy support and benefits, and it was not clear the provider had fully justified this through appropriate assessments.

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 and wider service.

Clients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in client areas and on their website.

Staff understood the policy on complaints and knew how to handle them. They were trained to resolve minor concerns and to refer more serious complaints to the senior team.

Managers investigated complaints and identified themes. Between January 2022 and October 2022, the service received 13 formal complaints. Operations managers identified COVID-19 restriction measures and staff attitude as the two main themes. Most complaints requested a refund of care fees.

Good

Substance misuse services

Managers shared feedback from complaints with staff although it was not evident outcomes were used to improve practice. The nature and outcomes of complaints indicated clients and their loved ones did not always fully understand the scope of the service. Most complaints related to a request for a refund because people did not feel the service had been delivered correctly or contractually. While the provider's customer service manager responded thoroughly to each complaint we reviewed, we were not assured the service subsequently took all possible steps to make sure clients and their relatives understood the scope and technicalities of the service in advance.

The service used compliments to learn, celebrate success, and improve the quality of care.

Are Substance misuse services well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the service and were visible in the service and approachable for clients and staff.

The registered manager and deputy manager had significant experience in managing and leading substance misuse services, including services for clients with high levels of risk. The registered manager was relatively new in post in this service and was working with the provider's operations managers to establish their post. Each team had a designated lead.

The provider supported staff to develop leadership and managements skills and recognised this as a key strategy to promote long-term staff commitment. The registered manager held a level five leadership qualification and a team leader was completing a level three leadership qualification. A senior support worker was completing a national level five qualification in leadership and management.

Staff said they felt supported by the manager and other senior staff and said they were easy to access.

Staff said the manager supported their development and helped them to access training and build practical skills.

Vision and strategy

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

The provider had a clear mission to deliver a whole-person approach to recovery that considered needs holistically and not just physically. Many staff had completed detox and addiction recovery programmes themselves and were open about this when working with clients as part of a strategy of empathy and understanding.

The service focused on family rehabilitation as much as individual detox and offered each client and their family comprehensive support.

The provider had established a lifetime alumni programme of support and 12 months of free aftercare. Named 'Alumni', this provided clients who had completed a treatment programme with access to social events and a support network.

Culture

Staff felt respected, supported and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff were demonstrably compassionate in the course of their work. They interacted with clients on an individualised basis and respected each individual's level of comfort with communication. One member of staff told us they could relate to client's struggles and their reward was to see people complete the programme and leave feeling happy.

Operations managers demonstrated a focus on culture and discussed this in monthly meetings. They recognised the emotive nature of care provided and the impact this could have on team coherence and staff satisfaction. Each manager discussed their key learning from the previous month as well as their single biggest success. They worked with managers to ensure staff were supported and had a voice in the work environment.

There was an overarching culture of fear of COVID-19 infections. The provider required clients and staff to test at least three times each week, with immediate isolation if a result was positive. Visitors were not permitted in the building. Operations managers found one member of staff had suggested clients suspend their treatment programme when others tested positive and return when there were no active cases. The senior team found this was due to the individual's anxiety around the pandemic.

The new registered manager had worked to stabilise the team after several months of escalating challenges and problems. This included staff being absent without leave and significant pressures on the team, with resulting absence from stress-related sickness. Staff spoke positively about the work culture and said they felt their welfare was important to the registered manager and other senior staff. However, it was not clear the provider had a suitable structure of support in place for staff. Evidence indicated one individual routinely worked over 75 hours per week with little support. Governance documentation indicated the provider's focus was on the individual's budget management not on their work-life balance. Another member of staff noted they often felt overwhelmed by work.

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.

The registered manager used a monthly key performance indicator dashboard to monitor the service. This included governance markers such as monitoring processes for staff training, incident tracking, and up to date actions from team meetings. The dashboard for 2022 was up to date and demonstrated an effective governance process.

Operations managers met monthly to review governance at provider level and at each location. We reviewed the minutes of meetings and saw the process was effective in monitoring different challenges, issues, and successes at each service and sharing the outcomes of each across all teams.

Management of risk, issues and performance

Good

Substance misuse services

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

The provider had an established system of risk and operational management. The registered manager acted on this locally, such as by tracking risks that needed to be added to the overarching risk register. At the time of our inspection there were 78 active risks. Each risk had a named, accountable member of the senior team and a graded risk assessment. The risk register was comprehensive and reflected the nature of the service, with a clear focus on client-based risk.

The head of compliance managed risks and performance at provider level and worked with each registered manager to understand service-specific challenges. Key local challenges had related to staffing pressures and a change of manager over the summer, a spike in medicines documentation errors, and complaints. There was evidence the senior team was working to address the issues.

Information management

Staff collected analysed data about outcomes and performance.

The registered manager presented and reviewed local data in monthly operations meetings. This included a discussion of key performance indicators, incidents, staffing figures, and complaints.

Staff completed training in information governance and data protection and there was a good culture of data protection and confidentiality.

Engagement

Managers engaged other local health and social care providers to ensure that an integrated health and care system was provided to meet the needs of people seeking care.

Staff worked within a professional boundaries policy established by the provider. The policy was up to date and staff completed training on managing appropriate relationships and levels of engagement with clients.

Staff provided each client with a printed induction booklet on admission. This helped orientate the individual and provided them with details of the services, therapy, and facilities available to them.

The provider asked each client to complete an exit survey on discharge. This helped to identify opportunities for improvement in support, training, and experience. Results indicated clients felt broadly positive about their care, the leadership team, and the provider. For example, in the previous 12 months 93% of respondents said they would recommend the service and 93% rated managers as good or very good. Clients rated therapists highly, with 97% rating their therapist as very good or good.

The provider carried out a staff exit survey but did not review location-level results.

The service operated an alumni scheme for clients, called ‘graduates’, who had successfully completed a course of treatment. Alumni returned to the lodge and met with current clients to discuss their experiences and post-discharge experiences.

Good

Substance misuse services

Learning, continuous improvement and innovation

The new registered manager and their team were demonstrably committed to stabilising the team after summer staffing pressures. Individual teams were focused on improving standards of care and service, such as the range of improvements made by the head chef.

The team recognised areas that had room for improvement and developed strategies to address these, such as the move to an electronic medicines management system.