# Banbury Lodge

## 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? | Good |

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

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

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

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

# Summary of findings

## Overall summary

This was our first inspection of Banbury Lodge. The service opened in April 2018.

We rated Banbury Lodge as Good because:

- The service was fully staffed, with a range of well trained and experienced staff. Staff put into practice the service's values, and had contact with managers at all levels, including the most senior.
- The provider placed a significant emphasis on staff training and professional development.
- The environment was clean, spacious and furnished to a high standard.
- The service had the appropriate arrangements in place to support clients with their detoxification in line with national guidance
- All clients had personalised and holistic care plans
- Staff stored client information on a securely accessible electronic case management system with other relevant records. Medical admissions records, including assessments, were stored in paper file separate from the electronic system. There were plans in place to address this.
- Care planning tools consistently reflected the 12 step philosophy of the service.
- Clients spoke very highly about their experiences of the service, their therapeutic relationships with staff and the impact the service had on their lives.
- There were policies in place to manage risk, including to clients leaving treatment prematurely and clients who were at risk of self-harm. All clients had risk assessments and detailed risk management plans for every identified risk.
- The service showed a commitment to quality improvement.

# Summary of findings

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Good

# Location name here

**Services we looked at**
Residential substance misuse services;

# Summary of this inspection

## Background to Banbury Lodge

Banbury Lodge in Oxfordshire is one of a group of services owned by UK Addiction Treatment, and is a private residential detoxification and rehabilitation service where clients fund their own treatment. The service was registered with CQC in September 2017, and opened in March 2018.

Banbury Lodge is a 23 bed unit providing a seven to ten-day detoxification and a 28-day rehabilitation programme to support clients over the age of 16 with substance misuse issues including alcohol and/or opiate dependency. The service also offers residential counselling to clients with gambling problems and eating disorders. The treatment of eating disorders and substance misuse fall within the scope of the service's registration, however the inspection carried out was of substance misuse treatment, as this was the treatment being received by the majority of clients.

The service offers a medically monitored detox for alcohol and opiate users. This means that clients may be given medicine to safely manage their withdrawal from substances and are supported by staff but do not require 24-hour medical supervision. If clients are opiate dependent, they are detoxified using dihydrocodeine, an opioid which can be used as an opiate substitute medicine. Clients who are alcohol dependent are detoxified using chlordiazepoxide which is a benzodiazepine. The primary ethos of the service is 12 step, however staff also use integrative or person centred counselling and dialectical behavioural therapy (DBT) skills. The 12 step approach is a set of guiding principles followed within an anonymous fellowship of others working to achieve abstinence from substances use or other addictive behaviours, and is a form of treatment sometimes referred to as mutual aid. There were 23 clients receiving treatment at the time of our visit.

Banbury Lodge is registered to provide:

Accommodation for clients who require treatment for substance misuse and treatment of disease, disorder or injury. A registered manager was in place.

## Our inspection team

The team that inspected the service comprised two CQC inspectors and one specialist advisor who was an RMN (Registered Mental Nurse) with a substance misuse background.

## Why we carried out this inspection

We undertook an unannounced, comprehensive inspection of this service as part of our routine programme of inspecting registered services.

## How we carried out this inspection

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

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

# Summary of this inspection

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

During the inspection visit, the inspection team:

- Carried out a tour of the building, including the clinic room, kitchen, communal areas and a client's bedroom
- interviewed the registered manager
- Interviewed six members of staff, including a senior therapist and registered nurse
- observed two group sessions
- gathered feedback from seven clients
- looked at eight client treatment records, including medicines records
- reviewed training records and staff supervision records
- looked at policies, procedures and other documents relating to the running of the service including 10 complaints and the service incident log.

## What people who use the service say

Clients gave universally positive feedback about the service and the support they received. Clients said that the support they received from their peers in the service was excellent and that staff and the manager went above and beyond their role to understand them. Clients also spoke highly of the physical environment and the food.

# 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 was fully staffed. Therapist caseloads did not exceed six clients at any one time.
- The building was clean and well-maintained. All clients had lockable en-suite bedrooms.
- All clients received a medical assessment by a consultant psychiatrist who prescribed detoxification medicine. The service employed a full-time nurse.
- Clients' physical health and withdrawal symptoms were assessed and closely monitored by staff.
- The service followed best practice in administering and monitoring medicine. Medicine reduction regimes were clearly recorded with evidence of regular audits.
- The service followed best practice in the detoxification of clients from substances, which staff carried out safely under instruction from a consultant psychiatrist.
- Client risk was well assessed prior to admission, at assessment and throughout their treatment. This included plans for clients' unexpected exits from treatment that addressed risk of overdose and ensured that carers were included.
- The service supported clients to maintain appropriate contact with families and partners, and had care plans for all clients around maintaining healthy relationships.
- The service had a good track record on safety and had no adverse events or serious incidents recorded since opening.
- Medical admissions records, including assessments, were stored in paper files separate from the electronic system. Other medical information, including GP summaries and test results were stored on the electronic system, along with risk assessments, care plans and daily updates. The parent organisation was in the process of moving all records on the case management system, and was piloting this at another site at the time of our visit.

### Are services effective?

Good

We rated effective as Good because:

- Clients had assessments prior to and on the day of their admission to the service.
- A consultant psychiatrist carried out physical and mental health checks on all clients before they began their detoxification treatment programmes.

# Summary of this inspection

- Staff completed and updated holistic care plans for clients on the eight client records we reviewed.
- Co-existing conditions, such as mental health support needs, were identified at the admission and risk assessment stages prior to admission, and supported through personalised care plans.
- Staff followed national guidance for people undergoing alcohol and opiate detoxifications.
- The service offered a group programme to support clients' overall wellbeing, including sound therapy, as well as individual counselling sessions.
- All staff received annual appraisals and six weekly supervision. Counselling staff received appropriate clinical supervision.
- The service had strong links to local 12 step recovery groups such as alcoholics anonymous and narcotics anonymous.
- All staff were trained in and had a good understanding of the Mental Capacity Act.
- The service used a suite of key performance indicators which included the number of clients successfully completing treatments and exit surveys.

## Are services caring?

Good

We rated caring as Good because:

- Staff treated clients with warmth and respect, showing compassion and understanding for the impact of their substance misuse. Staff showed a high degree of sensitivity to clients' emotional and spiritual needs, especially the impact of trauma and its role in addictive behaviour.
- All clients we spoke to spoke highly about the staff and the therapeutic relationships they had with them.
- All clients received a client handbook and induction on admission.
- Clients were involved in their care. They planned their detoxification with the consultant and this was reviewed throughout their admission.
- Care plans were highly personalised with evidence of detailed input from individual clients and their carers. Care notes showed staff and management to be responsive to changes in client's mood and presentation.

## Are services responsive?

Good

We rated responsive as Good because:

- There was a range of rooms for meetings, one to one sessions, group sessions, family visits and socialising. Clients had free access to the garden and smoking area.

# Summary of this inspection

- Clients were able to make hot drinks and snacks day and night. The chef prepared three meals a day with suggestions from a nutritionist, and clients could choose an alternative meal if they did not want what was on the menu that day.
- The nutritionist provided clients with personalised meal plans during their stay and post discharge.
- Clients personalised their bedrooms and could safely store their valuables during their treatment.
- The service had a range of activities seven days per week.
- The service gathered and monitored compliments and complaints, providing timely responses and refunds where agreed.
- The service offered a "recovery credit" system whereby clients leaving treatment prematurely could use the money they had paid for the remainder of their stay at another service within the group.
- Service user feedback was actively sought through surveys and community meetings, with actions displayed on a "you said, we did" board.

## Are services well-led?

Good

We rated well led as Good because:

- Managers were skilled, experienced and well equipped to lead the service, showing a hands -on approach as well as driving improvements to the service overall. The service had a clear definition of recovery which was based on the 12 step philosophy.
- The service had robust systems in place to ensure the service was adequately staffed, incidents were recorded, and staff received mandatory training, regular supervision and appraisals.
- The service ensured that a range of compliance audits took place regularly and that actions were followed up in a timely way.
- Staff and managers described high morale within the team and a high level of engagement with the wider organisation. In particular, staff felt that their learning and development was a high priority for the organisation.
- Senior managers were a regular presence in the service and approachable by staff.
- Staff understood the service's whistleblowing policy. No whistleblowing concerns had been raised with CQC in the 12 months prior to the inspection.
- The organisation set key performance indicators to measure the service's performance.

# Summary of this inspection

- The organisation showed a commitment to quality improvement, maintaining a log of local initiatives to improve service delivery and actively encouraging innovation.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the service provider's compliance with the Mental Capacity Act 2005 and, where relevant, the Mental Health Act 1983 in our overall inspection of the service.

Staff understood the importance of clients' capacity to consent to treatment and to understand their rights while they were in treatment. All staff were trained in and had a good understanding of the Mental Capacity Act. This training was part of their mandatory training programme.

Staff understood that capacity to consent to treatment could fluctuate through intoxication with substances or through the symptoms of a mental health problem becoming apparent during or after a detoxification treatment. In addition to completing a capacity checklist prior to admission and at the start of treatment the service had bespoke tools with prompts for staff to ensure that capacity was actively reviewed when necessary.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Residential substance misuse services** | Good | Good | Good | Good | Good | Good |
| **Overall** | Good | Good | Good | Good | Good | Good |

Good

# Residential substance misuse services

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

## Are residential substance misuse services safe?

Good

**Safe and clean environment**

The service had current health, safety and fire risk assessments completed by staff and external contractors. Legionella tests were carried out at the service at appropriate intervals. All actions were up to date. Daily, weekly and monthly environment checks were carried out by staff and managers, and records we reviewed showed regular audits and remedial actions completed where necessary.

The service had trained fire wardens and first aiders, with named staff members allocated at daily handovers. First Aid training and basic life support were mandatory training for all staff. equipment was maintained and available throughout the building.

The medicines cupboard was locked and in good order, and met the requirements for a controlled drugs cabinet. Stock medicines that were not controlled drugs but had the potential for misuse were stored within separate lockable boxes within the cabinet. No controlled drugs were being used at the service at the time of our inspection however a separate cabinet was also present with a controlled drugs record kept inside. The service nurse had the keys and a spare was held by the manager at all times. In the absence of the nurse the key would be held by a senior member of staff. The room had a room thermometer; staff monitored the room temperature, ensuring that medicines were stored at correct temperatures.

The medicines fridge was unlocked and in good order. The only medicine stored there was for clients' physical health issues, as detox medicines were stored in the locked cupboard. Staff checked the fridge's temperature daily and recordings showed it was within range.

The service had a digital blood pressure monitor; alcometer for detecting and measuring alcohol use; thermometer; and, a digital blood pressure monitor. The service was equipped with a defibrillator which all staff were trained to use. There was no resuscitation equipment in the service, and staff called the local emergency services when required. The service did not have an electro-cardiogram (ECG) machine for checking and monitoring cardiac function. The service nurse told us that if necessary an ECG would be requested from the client's own GP prior to treatment, and clients could be referred to the local hospital located close by during their treatment.

21 of the 23 rooms were single occupancy, and clients could choose to be allocated to a shared room for a lowered fee. All rooms were en-suite ensuring privacy for clients. One room on the ground floor was accessible for wheelchair users.

A lift was in use for clients in the early stages of detox who may have experienced dizziness.

Bedrooms were clean, lockable, well-furnished and were personalised by clients with photos and personal belongings. Valuables and prohibited or restricted items were stored in secure lockers in a staff only area on the ground floor.

Good

# Residential substance misuse services

All areas of the service were clean and well maintained including the rear garden. All areas of the service were clean and well maintained including the rear garden.

The service employed two full- time housekeepers who worked Monday to Friday. Clients were responsible for keeping their bedrooms tidy.

The entrance to the site was unlocked to vehicles and pedestrians, and access to the building was managed via a secure electronic access control system. Closed circuit television (CCTV) was used inside and outside the buildings and was monitored by staff in the main staff office. Clients were made aware of the CCTV and its purpose at induction and provided signed consent prior to admission.

The service had a comprehensive contingency plan outlining the process to ensure service continuity if the site was closed in an emergency. This included which medicines and equipment to take to another site.

**Safe staffing**

The service employed 21 full time members of staff; the registered manager, a nurse, six therapists, seven recovery support workers, two housekeepers, one administrator, one chef and two waking night staff.

The service retained the services of two consultant psychiatrists who carried out medical assessments and prescribed the detoxification medicines. Both visited the service regularly and provided out of hours medical cover with other psychiatrists retained by the parent organisation.

The service occasionally used bank staff who were known to the service and who covered sickness, holidays and unexpected absences as required. Training logs showed that these staff received the same mandatory training as permanent employees.

The manager could bring in extra staff when needed, for example, for a client requiring 1:1 support at night, to ensure the service was not short staffed. Sickness and staff turnover were low.

All staff had completed their mandatory training. The training included subjects such as medicines administration, infection control, safeguarding, and equality and diversity.

**Assessing and managing risk to clients and staff**

The service followed best practice in administering and monitoring medicines, for example, medicine was stored appropriately and all documentation detailing medicine that was administered to clients was witnessed by a second member of staff. All staff were trained in medicines management, understood the therapeutic use of the medicines they administered and identified the clients they administered medicine to by attaching their photos to medicine cards.

Medical admissions records, including assessments, were stored in paper files separate from the electronic system. Other medical information, including pre-admission information, GP summaries and test results were stored on the electronic system, along with risk assessments, care plans and daily updates. The parent organisation was in the process of moving all records on the case management system, and was piloting this at another site at the time of our visit.

The service pre-admission procedure included gaining GP details and permission to contact them, and the client records we reviewed showed that this was consistently followed.

Staff assessed risks to clients' health and wellbeing at admission using a risk assessment. They addressed risk areas such as suicidal ideation, harm to self and others, and stress. Identified risks were detailed in clients' risk management plans which were used to monitor risks throughout treatment.

Staff developed plans for clients' unexpected exits from treatment. This included addressing difficulties experienced during previous treatment attempts and how clients could apply learning from their past experiences to complete treatment. When clients wanted to leave prematurely prior to treatment completion, staff met with them to explore a safe exit. For example, where would they go to after leaving, managing the return of medicine they had brought with them, and gave relapse and overdose management advice. This was captured in a checklist and present in all care records we reviewed.

The service had a policy on managing violence and aggression. There were signs displayed in the service reminding clients that aggression was not tolerated. This was also detailed in the client handbook and treatment contract which clients signed on admission.

Good

# Residential substance misuse services

Clients' belongings were searched when they were first admitted to the service, in accordance with a search policy that clients were made aware of prior to admission. The client handbook detailed a list of items which clients were not allowed to have, such as aerosol cans or sharp objects. Some items were restricted and could be signed in and out at certain times, for example, hair straighteners and razors.

Clients were able to have visits from family members, as part of personalised care plans to support healthy relationships. Children did not visit the service, however visits were supported at appropriate locations where required.

The service had child and adult safeguarding policies. We observed discussion of safeguarding issues and of routine safeguarding enquiries being made, recorded and followed up through the minutes of meetings and care records. The safeguarding procedures and the process was displayed in the staff office. No safeguarding alerts were made in the reporting period prior to the inspection taking place.

Staff used the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA) to monitor any discomfort experienced by the clients undergoing alcohol detoxification. This meant they could measure when to adjust the reduction dose, in liaison with the consultant, to ensure clients were comfortable and safe. Staff used the Clinical Opiate Withdrawal Scale (COWS) to monitor clients' opiate detoxification symptoms.

If patients brought medicine to the service, for example, insulin for the management of diabetes, the consultant linked to the service was alerted to this. Staff held the medicine so they could check for any contraindications with the detoxification medicine they prescribed during clients' treatment. The consultant also checked the medicine dates and if it belonged to the client carrying it. The nurse was the medicines lead within the team, however in their absence a senior member of staff would carry out this function.

The service had a code of conduct for clients to read in the client handbook and in the treatment contract. It referred to issues such as remaining fully clothed when moving around the building, keeping communal areas clean and not bringing in books or other materials that would detract from recovery while in treatment.

**Track record on safety**

The service had a good track record on safety and had no adverse events and no serious incidents since opening in March 2018.

**Reporting incidents and learning from when things go wrong**

The service manager was responsible for reporting incidents to the operations manager. However, staff were able to do this in their absence. Incidents were reported using the service's internal incident template which was sent to the operational manager, which was reviewed centrally with learning and actions circulated appropriately. The team de-briefed after incidents in daily handovers.

**Duty of candour**

The organisation had a policy relating to the duty of candour, and we saw evidence in complaints records of transparency and accountability to clients and their families. This meant that they were open about what happened and offered an apology when things had gone wrong.

## Are residential substance misuse services effective?

(for example, treatment is effective)

Good

**Assessment of needs and planning of care**

Clients had a telephone assessment conducted by the admissions team prior to admission to assess their suitability for treatment. The assessment covered issues such as substance misuse history, physical health, mental health, and forensic history. The assessment also identified additional support needs relating to spiritual needs, numeracy and literacy.

The service also invited prospective clients to visit the service to further assess their suitability for the programme. This assessment process was in line with National Institute for Health and Care Excellence (NICE) guidance.

The service had clear entry criteria and accepted clients who were assessed as being able to psychologically engage in the treatment programme, were able to self-care, and had mobility in regard to using the stairs and moving

around the building. Referrals and enquiries were managed by a central pre-admissions team who would direct referrals to appropriate services within the group. This team ensured that clients understood the 12 step philosophy of the service and the spiritual, abstinence based nature of the 12 step programme and were happy with the approach. The service had clear exclusion criteria based on very high levels of risk, with an emphasis on assessing risk on an individual basis where these issues did not apply. Exclusion criteria applied to individuals with complex health needs that could not be safely managed and serious forensic histories including arson.

Client assessments were reviewed by the consultant prior to their physical examination and admission. The consultant carried out a physical examination of all clients prior to admission. The assessment included a blood test, and weight and blood pressure checks. We reviewed client records which showed that health issues identified were addressed prior to commencing treatment.

The social needs of clients, such as families, hobbies and accommodation, were assessed by the assessment team and again following admission by their allocated counsellor. These needs were used to develop the clients' care plans. These assessments were in line with NICE guidance. We reviewed personalised care plans for identified needs, including healthy relationships and education, training and employment.

All eight clients records we reviewed had holistic, comprehensive care plans that were personalised and captured the clients' perspectives and individual recovery goals. The language used in the care plans and the focus of the agreed goals strongly reflected the 12 step philosophy of the service. Through group work and one-to-one counselling clients were supported to achieve between two and three of the 12 steps during their 28 day stay at the service. Steps one to three are admitting they are powerless over substances and their lives have become unmanageable; coming to believe that a higher power can restore them to sanity; and making a decision to turn their lives over to the higher power. All clients had aftercare plans aimed at continuing this process.

Co-existing conditions such as mental health support needs were identified at the admission and risk assessment stages prior to admission. When clients were assessed by the psychiatrist on their first day of treatment, they also carried out assessments to identify co-existing conditions.

We saw evidence of personalised care and risk management plans to support clients with a history of self-harm and post-traumatic stress and for whom the emotional demands of treatment could pose a risk. We found that these risks were managed therapeutically by therapists and recovery workers in group and one to one work, with evidence recorded in care records.

Staff monitored clients' changing social needs, and physical and mental health needs during daily observation in the group and individual sessions, during clients' free time and by regularly asking clients how they were. This was in line with NICE guidance. Clients told staff if they experienced discomfort during their detoxification so staff could administer medicine to ease their symptoms. Evidence of this was recorded in medicine charts we reviewed.

**Best practice in treatment and care**

National Institute for Health and Care Excellence (NICE) guidance (the Orange Book 2017) was followed for people undergoing alcohol and opiate detoxifications and the service had policies for these. The psychiatrist prescribed dihydrocodeine for the management of opioid dependence however where a client expressed a preference for a different medicine on the grounds that it had been successful before or they had experienced side effects from dihydrocodeine then this could also be offered. The psychiatrist prescribed chlordiazepoxide for assisted alcohol withdrawal, and prescribed Vitamin B and Thiamine for treatment of co-existing deficiencies, in line with NICE guidance.

The detoxification policy was reviewed annually and covered aspects such as assessment, medical emergencies, prescribing regimes, vitamin replacement, monitoring and review.

The service offered a therapeutic group programme and individual counselling sessions using the 12-step approach person centred counselling and Dialectical Behavioural Therapy (DBT). The service also offered complementary wellbeing groups including sound therapy, mindfulness and reiki.

Staff engaged in weekly client record audits to ensure all client paperwork was up to date and signed appropriately. Staff fed their audit findings back to the team verbally in daily handover meetings.

Good

# Residential substance misuse services

The service used key performance indicators to measure the effectiveness of the service, which included some client outcomes, including early exits and treatment completed.

**Skilled staff to deliver care**

Staff engaged with relevant professionals involved in clients' care and treatment, especially those with additional health and social needs.

The service's staff team included a registered general nurse (RGN), therapists and support workers, counsellors and a visiting GP. All staff were experienced and appropriately qualified. Staff employed in counselling roles held appropriate qualifications and most were registered with the British Association of Counsellors and Psychotherapists (BACP), the professional standards body for people working as counsellors in the UK. The service manager was qualified in psychotherapy and to deliver clinical supervision to therapists. The nurse received clinical supervision from a senior nurse and non-medical prescriber (NMP) based at another service within the group.

Staff and bank staff received appropriate induction when they began working at the service.

All staff working with clients had access to specialist training, for example, annual dialectical behavioural therapy (DBT) skills. Three staff were being sponsored to undertake master's degrees in working with people with eating disorders, and two others to complete level 5 qualifications in leadership and management. Staff also had Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA) and Severity of Alcohol Dependence Questionnaires (SADQ) training. This meant they could use these tools in the assessment and management of clients' alcohol withdrawal. Staff were also trained to use the Clinical Opiate Withdrawal Scale (COWS) to monitor opiate withdrawals.

Client records showed that advice and information was provided to all clients around harm reduction, including prevention of overdose and transmission of blood borne viruses.

All staff received annual appraisals and six weekly clinical supervision and managerial supervision sessions. Information discussed relating to clients in clinical supervision sessions was updated in the relevant client records.

All staff received training in equality, diversity and human rights and this was part of their mandatory training programme.

The service manager addressed staff performance issues in supervision and followed the internal capability and disciplinary procedures where necessary. There were no staffing issues of this nature at the time of our inspection, however, the manager described effectively following these processes in a previous position working at another service within the group.

**Multidisciplinary and inter-agency team work**

All staff on the shift rota attended daily morning and afternoon handovers. The night workers wrote up night handover notes and these were shared the following morning to update staff on any issues. Information was handed over three times a day using a template including relevant standing items, including actions from the previous shift, risk management, safeguarding, health and safety and individual clients' issues and progress.

Staff attended monthly multi-disciplinary meetings. Minutes were distributed by email to all staff members. Information from non-attending relevant professionals, for example the GP, was gathered via email for use in the meetings.

The service had good links with external local services such as the police, local pharmacy, emergency dentist, social services, and criminal justice services. The local general hospital was very close and staff told us that they had forged effective links with the emergency department.

The service made contact with relevant services for clients who lived out of the area by telephone and sometimes by attending meetings. As the service accepted referrals from a wide geographical area this was mainly done on an individual basis.

The service had strong links to local recovery groups such as alcoholics anonymous and narcotics anonymous, with attendance at these meetings forming a key part of the therapeutic programme.

**Good practice in applying the Mental Capacity Act**

Staff understood the importance of clients' capacity to consent to treatment and to understand their rights while they were in treatment. All staff were trained in and had a good understanding of the Mental Capacity Act. This training was part of their mandatory training programme.

Good

# Residential substance misuse services

Staff understood that capacity to consent to treatment could fluctuate through intoxication with substances or through the symptoms of a mental health problem becoming apparent during or after a detoxification treatment. In addition to assessing capacity at assessment and at the start of treatment the service had bespoke tools with prompts for staff to ensure that capacity was actively reviewed when necessary. Staff assumed clients had capacity and the team assessed this throughout their detoxification. The service was not suitable for clients who lacked ongoing capacity to consent to treatment and interventions, so ongoing assessment was important to ensure clients were in the right treatment setting to meet their needs.

**Equality and human rights**

The service had an equal opportunity policy. All staff completed mandatory training in equality and diversity. Assessment paperwork showed evidence of identifying diverse needs such a spiritual and language needs, and we reviewed care plans that addressed cultural influences issues around substance use and dependency. The service engaged people with support needs relating to parenting, drug and alcohol use, and mental health needs.

The service's therapeutic agreement and client handbook stated that discrimination or abuse to any clients in regard to difference and diversity was not acceptable.

Clients agreed with a therapeutic contract in advance of treatment. This contract outlined clients were not permitted to use their mobile phones during the first week of their detoxification. However, they could use it for short periods in the evenings for the rest of their treatment. When clients needed to make emergency calls to family they arranged it with their counsellor. All calls made by clients using the clinic phone were observed by a staff member. During their treatment clients were not allowed to leave the premises without staff to accompany them and this was agreed to support their safety.

**Management of transition arrangements, referral and discharge**

Counselling staff completed continued recovery plans with clients including discharge plans. These included details about how clients continued their recovery and where they would live after treatment. The assessment also identified support clients needed, for example, counselling, group work, training, volunteering work, and local mutual aid such as alcoholics anonymous (AA).

Follow up one-to-one counselling at another UK Addiction Treatment (UKAT) treatment service more local to the client's home was an option if clients chose to self-fund this. All clients could continue to access weekly aftercare support groups for up to two years post discharge, on-site.

The service used a suite of key performance indicators, which included monitoring the number of clients completing treatment and the completion of exit surveys.

The parent organisation was in the process of establishing post-treatment follow-up contact by clients who had successfully completed treatment and been recruited to offer peer led aftercare support.

## Are residential substance misuse services caring?

Good

Staff treated clients with warmth and positive regard, showing compassion and understanding for the impact of their substance misuse. We observed staff using positive language and speaking respectfully and sensitively about clients. Staff showed a high degree of understanding of clients' emotional, psychological and spiritual needs, in particular the impact of trauma and its relationship to substance misuse.

All clients received a detailed client handbook and induction on admission, with evidence and signatures recorded on all eight case records we reviewed.

Clients were involved in their care. They planned their detoxification with the psychiatrist and this was reviewed throughout their admission. The counselling approach allowed therapists to draw on different models according to clients' preferences, for example, psychodynamic or integrative methods. Clients could request different medicines for their opiate detox, for example, physeptone or buprenorphine, based on past experiences of success or otherwise, which the psychiatrist would consider within clinical guidelines.

Good

# Residential substance misuse services

Clients were actively supported to maintain and rebuild relationships with families and partners and individualised care plans partly focussed on healthy relationships, including parenting.

## Are residential substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

### Access and discharge

Clients were admitted quickly following initial assessment, sometimes on the same day as their assessment was completed. As self-funders the clients had the option of choosing an alternative treatment provider if a place was unavailable at the time they wanted to start treatment.

Clients were discharged during the day so they could travel home or on to their next stage of treatment as appropriate. Weekly aftercare group sessions were available to clients requiring support following discharge, which staff told us were well attended.

Clients could choose to self-fund one-to-one counselling in addition to this.

### The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms for meetings, one to one sessions, group sessions, family visits and socialising. All rooms were quiet and private and had signage to alert anyone passing to be aware of counselling or meetings taking place. An outside pod building situated in the grounds was used for visits and group work. The service had a well equipped gym with equipment that was checked and serviced regularly.

Clients had free access to the garden and smoking area.

Clients stored their mobile phones in individual lockers for the duration of their treatment. Only staff had access to these lockers and obtained items for clients at their request. Clients were permitted to make emergency calls where necessary with the support of their counsellors. All calls made using the clinic phone were made in the office where staff could listen to help protect people's recovery and safety. Clients agreed this as part of the therapeutic agreement.

Food was prepared daily by the chef. Staff ensured that dietary needs relating to cultural and spiritual needs were met, having been clearly identified pre-admission.

Clients told us that the food was a very good standard and the menus had been formed following training by a nutritionist. The nutritionist suggested personalised meal plans for individual clients during treatment according to their circumstances and also provided them with plans to take with them after treatment completed.

Clients were able to make hot drinks and snacks day and night and had access to their own kitchen next to the communal lounge area.

Clients were invited to personalise their bedrooms in the client handbook and the rooms we viewed were well furnished and spacious.

Clients stored valuable items, such as money, mobile phones, laptops and mp3 players, in secure lockers which were situated in a locked room only accessible by staff. Clients requested and accessed items as required, for example their mobile phones in the evenings. Clients had codes to lock their bedroom doors so they could keep other valuables in their rooms if they wanted to.

The service had a range of activities seven days per week such as art, music, yoga, mindful meditation, therapeutic groups, sound therapy, visiting time, and use of the gym. Clients attended 12 step groups throughout the week, including Alcoholics Anonymous, Narcotics Anonymous and Overeaters Anonymous. This was in line with NICE guidance.

### Meeting the needs of all clients

All clients received a client handbook on admission. The handbook included details on behaviour and boundaries, confidentiality, information sharing, admission procedure, care planning, treatment, and leisure activities.

All clients received an induction to the service on their day of admission.

Literature was available within the service about the treatment approaches of the service, including the 12-step philosophy.

Good

# Residential substance misuse services

The service had one room, based on the ground floor, that was adapted for wheelchair access. A lift was present for people with temporary risk of trips and falls in the early stages of detox.

Information on the complaint procedure was detailed in the client handbook which all clients received on admission.

There was access to translators and signers if required.

The service recorded compliments and complaints. 11 formal complaints had been raised in the 12 month reporting period prior to our visit, two of which had been upheld. Complaints were responded to in a timely way and investigated promptly.

The service carried out satisfaction surveys with clients after they had been in treatment for seven days, to identify any areas for improvement arising from their pre-admission and start of treatment that could then be acted on to improve the remainder of their stay

## Are residential substance misuse services well-led?

Good

### Vision and values

The service had a clear definition of recovery displayed in staff areas which was based on the 12 step philosophy. The service's vision and mission statements were based on these values and outlined in the client handbook.

Staff knew who the most senior managers were in the organisation and received frequent visits from the head of operations, operations manager and quality and governance manager. Managers described an "open door policy" towards everyone in the service, with the registered manager interacting with clients regularly and offering professional clinical supervision to staff as well as leading on management issues.

### Good governance

The organisation used a range of key performance indicators to monitor the performance of the service. In addition to business related issues like occupancy, retention and requests for refunds, the organisation monitored safeguarding referrals, medication errors and the results of exit surveys capturing client satisfaction.

The service had effective systems in place to ensure that the service was adequately staffed, incidents were recorded, staff received mandatory training, regular supervision and appraisals.

The registered manager had enough authority to lead the service effectively and had access to administrative support. Senior management routinely based themselves at the service, were known to the staff team and closely supported the manager.

The manager had the ability to submit items to the organisation's risk register.

### Leadership, morale and staff engagement

Staff told us they felt able to raise concerns without fear of victimisation, and would be comfortable approaching senior managers directly if needed.

Staff described feeling positive about their jobs, with exceptional support from colleagues and a warm, respectful professional atmosphere within the team.

Staff understood the service's whistleblowing policy. No whistleblowing concerns were raised with the CQC for the 12-month reporting period prior to our visit.

Managers operated an open door policy for staff and clients, and had awareness of individual client care plans and risk issues as well as strategic oversight of the service, including measures to drive improvements.

### Commitment to quality improvement and innovation

The service catered for self-funding clients from any geographical location, so did not engage with local quality improvement and monitoring networks.

The service had evidence of initiatives to improve the service. The service maintained a quality improvement log. The electronic case management system was being developed to incorporate medical admissions information, and the parent organisation had developed a programme of recruiting and training former clients to contact people post discharge and offer peer support.