Closereach

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

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Staffing levels had been set using ratios of client to staff recommendations from the British association of counsellors and psychotherapy of one member of staff to six clients as the minimum requirement. Clients had up to date comprehensive risk assessments and all staff involved in administering medicines had undertaken required training.
- Clients had recovery care plans that were personalised, holistic and had goals identified. Staff provided group work and one-to-one sessions suitable for clients in rehabilitation and counsellors had a minimum qualification of either level three counselling qualification or equivalent.
- Staff were kind, patient and supportive to clients and care was client focused. New clients received a welcome pack of information, and a pack of toiletries and new bedding which they were able to take with them when they left.

Summary of findings

- Staff morale was good and staff said they felt well supported by their manager. Staff received regular supervision and appraisal and new staff received induction to prepare them for working within the service.

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

- A fridge that was used for storing medication had been out of temperature range on 19 out of 27 days recorded and no action had been taken to correct this. This meant that medication that needed storing within specific temperature ranges may have lost its efficacy.
- Staff did not check that clients who were self-administering medication such as antibiotics were taking them as prescribed or completed the course. Medication administration risk assessments contained no information about what might trigger certain conditions, such as asthma, or what to do if their condition escalated.
- Clients were given some medicines outside of the original pack. This was secondary dispensing and can lead to accidental errors.
- Clients' care was discussed at regular multi-disciplinary team meetings although notes from these meetings were not added to the client's care record to show that this had happened or to demonstrate the outcome of the discussion.
- None of the bedroom doors had locks on them and we saw that a member of staff entered clients' bedrooms doors without knocking.
- Although staff demonstrated a good understanding of mental capacity, Mental Capacity Act training was not mandatory for staff.

Summary of findings

Contents

Closereach

Services we looked at:
Substance misuse services

Summary of this inspection

Background to Closereach

Broadreach House is a provider and registered charity, offering treatment and support services for men and women experience substance abuse. It consists of three residential services called Broadreach, Longreach and Closereach, and a community day service called Ocean Quay.

Closereach is a 18 bed rehabilitation service for men who have completed detoxification. The minimum stay is three months, with an option to stay for a further three months. There were 15 clients accommodated when we inspected.

The majority of clients are funded by community drug and alcohol services and local authorities.

The service had a registered manager.

The provider is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse

The provider has previously been inspected in 2012, 2013, 2014 and 2015.

Our inspection team

The team that inspected the service was led by CQC inspectors Julia Winstanley and Sarah Lyle, and comprised a specialist CQC pharmacist inspector, a CQC assistant inspector, and a consultant psychiatrist who had experience of substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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?

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

- visited the location, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with four clients
- spoke with the registered manager

Summary of this inspection

- spoke with six other staff members employed by the service provider, including a healthcare coordinator and counsellors
- spoke with one volunteer
- observed one treatment group
- collected feedback using comment cards from three clients
- looked at four care and treatment records
- looked at medicines management
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients at Closereach were very positive about the staff and described them as kind, caring and supportive, and treated people with respect and patience. However, they said that there were not enough staff and that they thought staff were sometimes stressed. We were told that not all staff knocked before going into their bedrooms, although most did. Clients at Closereach told us that the food was good but felt there could be a better range of activities away from the house, and that some activities that were advertised in the brochure, such as Indian head massage or zimbate (which is a type of natural healing) did not take place. All the clients at Closereach said they would like more life skills coaching and more one-to-one support

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- There was a refrigerator for storage of medicines but records showed that the fridge had been out of range for 19 out of the 27 days recorded. No action had been taken to correct this. This meant that medication that needed storing within specific temperature ranges may have lost its efficacy.
- Medication administration risk assessments were not personalised and contained no information about what might trigger certain conditions, such as asthma, or what to do if their condition escalated.
- One client's medication chart did not indicate that a client's medication was being administered by the GP surgery and therefore it appeared as if the client had not received that medication since the middle of August.
- Medicines suitable for self-administration were risk assessed for abuse potential, but not for health associated risk. For example, staff did not check that they were taking them as prescribed or completed the course.
- Clients were given some medicines outside of the original pack. This was secondary dispensing and can lead to accidental errors.

However, we also found the following areas of good practice:

- The building was clean, had good furnishings and was well-maintained
- Staffing levels had been set using ratios of client to staff recommendations from the British association of counsellors and psychotherapy of one member of staff to six clients as the minimum requirement.
- Clients had up to date comprehensive risk assessments. Risk assessments were completed on admission, at a six week review, and at an end-of- treatment review and after any incidents.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- Staff undertook their own assessment in addition to the referrer's information. All four records that we looked at had assessment of drug use, injecting history, past treatment and blood borne viruses. All had evidence of consent to treatment, information sharing and confidentiality agreements.
- Clients had recovery care plans that were personalised, holistic and had goals identified.
- Staff provided group work and one-to-one sessions suitable for clients in rehabilitation and included recovery maintenance and life story work. Clients could access a range of courses from the provider's day care service such as a stress management course. A number of clients from the service were working with a local theatre company.
- A member of staff was trained in eye movement desensitization and reprocessing therapy which was used to help with the symptoms of post-traumatic stress disorder.
- Counsellors had a minimum qualification of either level three counselling qualification or equivalent.
- Daily handovers took place, so that all staff were aware of issues that had occurred during the previous shift.

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

- Clients' care could be discussed at regular multi-disciplinary team meetings although notes from these meetings were not added to the client's care record to show that this had happened or to demonstrate the outcome of the discussion.
- Mental Capacity Act and Deprivation of Liberty Safeguard training was not mandatory for staff.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff were kind, patient and supportive to clients and care was client focused.
- Clients told us that they felt safe and that the food was good, and that the therapeutic approach was helpful.
- New clients received a welcome pack of information, and a pack of toiletries and new bedding which they were able to take with them when they left.
- Clients who had been at Closereach for a while buddied people who were new to the service, to help them settle in.
- There were opportunities to feedback about the service and all the clients we spoke to knew how to complain.

Summary of this inspection

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

- We observed a member of staff entered client's bedrooms doors without knocking.
- Some activities that were advertised in the brochure gave the impression that one-to-one support and activities, such as sailing and massage took place more often than in reality.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There was clear exclusion criteria which meant that referrers and staff knew when a client would not be accepted into the service.
- The provider managed a range of supported housing locally which clients could move on to.
- Clients could bring personal items with them and we saw that clients had made their rooms comfortable and individual and there were safes in each room to store valuables.
- The provider had taken steps to ensure that it was as accessible as possible to people with restricted mobility despite the challenges of being situated in a listed building.
- There were two comfortably furnished living rooms that could be used for groups and a large kitchen dining area and outside space.

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

- We found that the provider needed to review its policy of having no locks on bedroom doors.
- There were three single rooms, and the rest were shared rooms for a maximum of two people. None of the bedrooms had en suite bathroom facilities.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- There was a clear organisational structure with defined responsibilities for governance and for accountability.
- Board meetings took place every two months and the venue rotated between the providers different sites, so that it took place at Closereach once every six months.

Summary of this inspection

- The provider reported to national drug treatment monitoring system and was part of the clinical governance forum for Plymouth.
- Staff received regular supervision and appraisal and new staff received induction to prepare them for working within the service.
- Staff morale was good and staff said they felt well supported by their manager.
- Senior staff were supported to undertake a leadership course.

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

- Some audits were not effective in identifying areas of the service that needed improvement or did not result in action being taken.
- The provider had not clearly defined their visions and values.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated an awareness and understanding of mental capacity. However, Mental Capacity Act and Deprivation of Liberty Safeguard training was not mandatory for staff and only 50% of staff had undertaken Mental Capacity Act training.
- Mental capacity was assumed as well as assessed before admission, and clients who lacked capacity were not admitted. Clients had to consent to admission to the service. There were brief guides to the Mental Capacity Act and Deprivation of Liberty Safeguards on the wall in the staff office, to aide staff by providing a quick reference. There was evidence of consent to treatment and the sharing of information in the care records that we looked at.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- The building was a listed house which made alterations to the building difficult. There were ligature points throughout the building, however, the client group were low risk and people who were at risk of self-harm or suicide were not admitted. The building was clean, had good furnishings and was well-maintained. Clients helped with cleaning as part of preparation for being discharged.
- There was no clinic room and controlled drugs were not kept on the premises.
- Environmental risk assessment were undertaken and staff recorded issues requiring maintenance for the provider's maintenance staff. The provider held a contract with a local waste management company for clinical waste collection.

Safe staffing

- The registered manager also managed the provider's women-only rehabilitation service (Longreach) and split their working week between the two services. There was a senior counsellor, one counsellor and a trainee counsellor, three support workers and a health coordinator who was responsible for medicines management. There was one member of administration support and a housekeeper. A support worker lone-worked in the evenings with access to telephone support from a manager, if needed. There was no over-night staffing. Three volunteers worked for the service.
- Staffing levels had been set using ratios of client to staff recommendations from the British association of counsellors and psychotherapy of one member of staff to six clients as the minimum requirement. There were no vacancies. Unfilled shifts were filled by offering existing staff additional hours or using bank support workers from other services that were run by the provider. Agency staff were never used.
- All staff were up to date with mandatory training, which included adult safeguarding, child protection, fire awareness, and conflict resolution.

Assessing and managing risk to clients and staff

- The service required referrers to provide a risk assessment. Risk assessments were also completed on admission, at a six week review, and at an end-of-treatment review and after any incidents. All new updates were recorded in a different colour so that staff could quickly see what had changed.
- All four client records that we looked at had up to date comprehensive risk assessments. All had a risk management plan, although one had minimal detail. All the care records we looked at had plans for unexpected exit from treatment although two of these would have benefited from more detail regarding overdose prevention. Staff were able to give us examples of working with clients to reduce risk. For example, collaboratively working with a client who self-harmed to reduce the use of high risk ways of self-harming and encouraging the use of relaxation techniques.
- Items that were restricted were appropriate for the setting and client group and were explained to clients.
- All staff involved in medicines processes had undertaken required training. Clients' allergies to medicines were clearly recorded on medication administration record charts. Medicines given to clients

from the homely remedy list were recorded and monitored. Homely remedies were treatments for minor ailments that could be bought and did not require a prescription.

Track record on safety

- The provider had reported that a total of two serious incidents required further investigation between May 2015 and May 2016. There had been two serious case reviews which had been fully investigated with action taken to prevent reoccurrence and evidence of lessons learnt.

Reporting incidents and learning from when things go wrong

- There was a clear procedure for reporting incidents and staff were encouraged to report. Staff gave us examples of the type of incidents that they reported, which included relapse. Incident reports included a graded risk matrix. Incidents were discussed in handover meetings and the provider was able to demonstrate learning from incidents, For example, a serious incident had occurred due to a faulty window fastener and this had led to staff undertaking a weekly check of all windows.

Duty of candour

- We looked at incident investigations and complaints management. These showed that the provider adhered to duty of candour requirements.
- Medication that required cold storage was not stored securely. There was a refrigerator for storage of medicines but records showed that the fridge had been out of range 19 out of 27 days recorded. No action had been taken to correct this. This meant that medication that needed storing within specific temperature ranges may have lost its efficacy.
- Medication administration record folders contained risk assessments for people including asthma, but these were not personalised and contained no information about what might trigger certain conditions, such as asthma, or what to do if their condition escalated. Medication administration record charts were generated in-house. There was no evidence of who had generated the chart or that they had been checked by a second person for accuracy. One client's medication chart did not indicate that the client's medication of an antipsychotic medication was being administered by the GP surgery and therefore it appeared as if the client had not received that medication since the middle of August.
- Clients were supported to self-administer medicines when leading up to discharge in order to regain independence. Medicines suitable for self-administration were risk assessed for abuse potential, but not for health associated risk. For example, antibiotics were given to clients to self-administer but staff did not check that they were taking them as prescribed or completed the course. Clients were given some medicines to take themselves over the course of a week without any prescribing or dose information and outside of the original pack. Staff cut the required number of tablets from the strips and gave these to clients. This was secondary dispensing and could lead to accidental mix-ups and errors. We raised this with the provider who took steps to address this.
- Staff understood safeguarding. Staff were up-to-date with adult safeguarding training, but one member of staff had not received children's safeguarding training, however, all staff understood the principle of children's safety being paramount. The service had safeguarding leads for adults and children. There was a safeguarding policy which had been written in line with the local authorities guidelines. The local authority provided adult safeguarding training. Safeguarding referrals were recorded and discussed at senior board meetings.
- A member of staff lone worked in the evenings and could access help from one of the provider's on-call managers via the telephone. Staff felt that arrangements for lone working, and for women working in an all-male unit, were safe and told us that there had not been any incidents when they had felt at risk from clients because risks to staff were considered before accepting new clients.

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

Assessment of needs and planning of care

- We looked at four client's care records.

Substance misuse services

- The service kept paper care records. The provider was hoping to move to electronic care records in future, but did not have a date for when this would happen.
- All pre-assessment information was filed and accessible, such as assessments from the provider's detoxification unit, or from the referrer if being referred from elsewhere. If the client had been referred by local community drug and alcohol services, information would be held on the regional electronic record system, and staff from Closereach could access this. Staff undertook their own assessment in addition to the referrer's information. All four records that we looked at had assessment of drug use, injecting history, past treatment and blood borne viruses. All had evidence of consent to treatment, information sharing and confidentiality agreements.
- All four had recovery care plans, although one out of the four had not been updated in the previous six weeks. All were personalised and holistic and had goals identified however, clients own strengths were not always clearly identified. Clients' care could be discussed at regular multi-disciplinary team meetings although notes from these meetings were not added to the client's care record to show that this had happened or to demonstrate the outcome of the discussion.
- Patient notes were stored securely in lockable cabinets within locked rooms.

Best practice in treatment and care

- Staff provided group work and one-to-one sessions suitable for clients in rehabilitation and included recovery maintenance and life story work. Alternative therapies, such as acupuncture were available and all clients attended alcoholics anonymous or narcotics anonymous in the local community. Clients were supported to develop life skills to prepare for independent living. This included cleaning, and peers supported each other to improve these skills. Clients could access a range of courses from the provider's day care service (Ocean Quay). For example, four clients were undertaking a stress management course at Ocean Quay and the service assisted clients to engage with local colleges and universities to get involved in further training and education. Clients cooked for themselves at weekends, however, there was limited support to develop cooking skills and food was prepared for clients five days a week.
- A member of staff was trained in eye movement desensitization and reprocessing therapy which was used to help with the symptoms of trauma. There was a clear policy and flow chart for eye movement desensitization and reprocessing therapy, with referrals discussed at the multi-disciplinary team meeting and with the provider's psychiatrist to agree suitability.
- A number of clients from the service were working with a local theatre company. There was an on-site gymnasium and clients were encouraged to use this regularly.

Skilled staff to deliver care

- Counsellors had a minimum qualification of either a level three diploma in professional counselling qualification or an equivalent accredited course. The counselling qualifications were approved by the British Association of counselling and psychotherapy.
- All staff received regular one-to-one supervision and could also access group supervision. Counsellors were able to access external supervision, and were provided with a list of suitable supervisors to choose from. New staff received induction, which included medicines training. New counsellors observed group sessions before taking responsibility for facilitating the group.
- Poor staff performance was addressed promptly and effectively by the registered manager

Multidisciplinary and inter-agency team work

- The registered manager attended weekly multidisciplinary team meetings at Broadreach, which was the provider's detoxification service. Representatives from the provider's other services attended these meetings as well as the consultant psychiatrist and medical officer. New referrals, planned admissions, unplanned discharges and safeguarding were discussed in the meetings, which were minuted. The minutes were sent to all staff. The provider's consultant psychiatrist saw clients if required and liaised with the client's GP regarding any mental health issues.

- Daily handover meetings took place, so that all staff were aware of issues that had occurred during the previous shift.

Good practice in applying the MCA

- Mental Capacity Act and Deprivation of Liberty Safeguard training was not mandatory for staff and only half the staff had undertaken Mental Capacity Act training. Mental capacity was assessed before admission, and clients who lacked capacity were not admitted. Clients had to consent to admission to the service. There were brief guides to the Mental Capacity Act and Deprivation of Liberty Safeguards on the wall in the staff office, to aide staff by providing a quick reference. There was evidence of consent to treatment and the sharing of information in the care records that we looked at.

Equality and human rights

- Equality and diversity level two training was mandatory for all staff and the provider had an equality and diversity policy.

Management of transition arrangements, referral and discharge

- Referrals were accepted from community drug and alcohol services and from the provider's own detoxification service. Discharge was planned with the client prior to admission and throughout the treatment. For planned discharges formal reports were sent to the referrer, and the counsellor made contact with the referrer within 24 hours of discharge. When clients left early information was shared with the GP, care manager and next of kin. Clients were discharged to the care of the community drug and alcohol teams.
- The provider managed a range of supported accommodation in the local area that clients could move on to.

Are substance misuse services caring?

Kindness, dignity, respect and support

- We observed that staff were kind, respectful, patient and supportive to clients and care was client focused. Staff had a good understanding of clients' needs and interacted with clients in a friendly manner. The services had a number of thank you cards on display. Staff encouraged clients to let them know if they needed help or support. However, we observed that a member of staff entered client's bedrooms without knocking on the doors first.
- We spoke to four clients and collected three comments cards. Clients told us that they felt safe and that the food was good, and that the therapeutic approach was helpful. They said that staff were kind and supportive. However, they told us that they felt there were not enough staff and that the staff were sometimes stressed because they had too much to do.
- Clients told us that the brochure gave the impression that one-to-one support and activities, such as sailing, took place more often that in reality. Staff told us that the brochure was due to be updated to make sure it more accurately described what was available.

The involvement of clients in the care they receive

- New clients received a welcome pack of information, and a pack of toiletries and new bedding which they were able to take with them when they left. Clients were given a tour of the building on arrival, were inducted to the gym and informed about fire safety. Clients who had been at Closereach for a while buddied people who were new to the service, to help them settle in. The buddy's role was to help new clients settle in. People who had been given the opportunity to be a buddy told us that being given this role had helped their confidence
- Clients told us that they did not have their own copies of their treatment plans but could ask to see them at any time.
- There were opportunities to feedback about the service and all the clients we spoke to knew how to complain. House meetings took place once a week, and feedback, complaints and issues were discussed. Client could complete evaluation forms every six weeks so that the service could look for themes and learning.
- Clients were able to have visits from family, including children. Children were accompanied if necessary and visits were planned in advance. Private space was available to meet although there was no designated family room.

Substance misuse services

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

Access and discharge

- The service was only available to men, and clients who were referred needed to have completed detoxification. There were clear exclusion criteria. For example, the service did not accept clients who had a conviction for arson or offences against children, or people with severe mental health problems. Length of stay varied depending on funding authority but was usually for at least twelve weeks. The provider requested extended funding if it was felt that the client needed more than 12 weeks residential rehabilitation.
- The service had three vacant beds at the time of inspection. This allowed the service to be responsive in accepting new referrals as well as having sufficient numbers for the service to be sustainable.
- The provider managed a range of supported housing locally which clients could move on to. Discharge was not delayed unless a longer period of rehabilitation was felt to be clinically appropriate and the funding authority had agreed to fund a further period of treatment.

The facilities promote recovery, comfort, dignity and confidentiality

- There were three single rooms, and the rest were large shared rooms for a maximum of two people. There was a screen between the two bed areas to give some privacy. Suitability and safety for sharing bedrooms was considered as part of the pre risk assessments. No bedrooms had ensuite bathroom facilities. There were two comfortably furnished living rooms that could be used for groups and a large kitchen dining area and outside space. There was a small room that could be used to make private phone calls.
- Clients could bring personal items with them and we saw that clients had made their rooms comfortable and individual. There were safes in each room; however none of the bedroom doors had locks on them. This meant that clients could not be sure that there personal possessions were safe and that there rooms were private and we saw that a member of staff entered client's rooms without knocking. This was a breach of clients' privacy and dignity.
- Clients were able to keep the duvet, pillows and bedclothes that they were given on arrival and take these with them when they were discharged.
- Food was prepared by cooks during the week and at weekends clients prepared their own food. Clients were able to access snacks and drinks and told us that the food was of good quality. A range of healthy food was available and the cooks encouraged clients to eat fruit and vegetables. At weekends clients cooked for each other.

Meeting the needs of all clients

- Closereach was an old house and a listed building, which made alterations difficult. However, the provider had taken steps to ensure that it was as accessible as possible to people with restricted mobility. There was a ramp to access the building form outside and a downstairs bedroom with some adaptations to accommodate people with limited mobility the narrow corridors were too small for some larger wheelchairs.
- Staff could access interpreters and information in different languages if needed. Leaflets in other languages were sourced as needed.
- The cook catered for a range of diets such as vegan, halal and gluten free and provided healthy options.

Listening to and learning from concerns and complaints

- There had been one complaint received in the previous 12 months. This was being investigated by the manager of the provider's detoxification unit because the complaint was about staff.
- Staff knew the complaints process and there was a policy in place. We saw that this had been discussed at a recent staff meeting. Attempts were made to manage concerns informally and when this was not successful the registered manager was responsible for investigating formal complaints. Staff were familiar with the complaints process in the staff handbook and it was part of the induction process. Complaints were audited quarterly.

Substance misuse services

- Clients were familiar with how to complain and there was a suggestion box in the main entrance hall. There was information on how to complain in the welcome pack for clients.
- Clients were asked to complete service evaluation forms every six weeks. These were audited every three months by the registered manager to look for themes and opportunities to learn and improve.

Are substance misuse services well-led?

Vision and values

- Closerach had a philosophy with a clear aim and objectives that were recovery focused and individual. All staff were aware of the philosophy and values. These were set out in the welcome pack to clients. However, the provider had not clearly defined their visions and values.

Good governance

- There was a clear organisational structure with defined responsibilities for governance and for accountability. The senior leadership team were actively involved in the service. Organisational risks were identified on a corporate risk register. This was graded and had control measures and was reviewed by the board of trustees.
- Board meetings took place every two months and the venue rotated between the providers different sites, so that it took place at Closereach once every six months.
- The provider reported to the national drug treatment monitoring system and was part of the clinical governance forum for Plymouth.
- The registered manager had experience of managing the provider's women-only rehab service but was relatively new to the role of manager of Closereach, having taken the role on three months previously. The manager had identified areas for improvement and was starting to implement changes as a result of this, for example, staff had been asked to improve the level of detail in risk assessments.
- The manager undertook a range of audits, including treatment plans, care notes and complaints, to monitor standards and identified areas of improvement. Staff received regular supervision and appraisal and new staff received induction to prepare them for working within the service, and all staff were up to date with mandatory training.
- Some audits were not effective in identifying areas of the service that needed improvement or did not result in action being taken. For example, medication fridge temperatures were not checked regularly and monitored and action had not been taken when the temperatures were out of range for safe storage of medicines,
- There was part time admin support which freed up time for counsellors and support workers to spend with clients.

Leadership, morale and staff engagement

- We were not made aware of any bullying or harassment and staff told us they knew how to whistle blow.
- Most staff told us that they enjoyed their work and were supportive of each other.
- Staff morale was good and staff said they felt well supported by their manager.
- Senior staff were supported to undertake a leadership course.

Commitment to quality improvement and innovation

- The service was not involved in innovation.
- The manager was fairly new in post and was committed to quality improvement and had identified areas for improvement, for example, the quality of record keeping, and had begun to support staff to improve. The manager had also carried out research on unplanned discharge

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that medicines that require cold storage in a refrigerator are kept within the manufacturers recommended range.
- The provider must ensure that all medicines given to clients to self-administer have the legally required prescribing and dispensing information, including dose instructions and patient name.

Action the provider SHOULD take to improve

- The provider should ensure that people taking their own medicines are taking them as prescribed.
- The provider should ensure that risk assessments for peoples medicines are personalised and contain information relating to that person's condition.
- The provider should ensure that all staff undertake Mental Capacity Act training as part of their mandatory training programme.
- The provider should review the provision of bathroom facilities and consider options for providing ensuite rooms.
- The provider should ensure that staff respect client's right to privacy and dignity. This includes ensuring staff always knock before entering a client's bedroom and reviewing whether or not clients are to lock their bedroom doors or not.
- The provider should ensure discussions about a client's care, and any outcomes, in a team meeting are recorded in the client's care record.
- The provider should review the auditing process to ensure that all audits undertaken are effective in identifying areas for service improvement.
- The provider should ensure that they follow through on their work to accurately represent to potential clients the activities on offer at the service.
- The provider should ensure there is a clearly defined visions and values statement for this service, and that this is shared with clients and staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The provider was not ensuring that medicines that required cold storage in a refrigerator were kept within the manufacturers recommended range. Not all medicines given to clients to self-administer contained the legally required prescribing and dispensing information, including dose instructions and patient name. Regulation 12(2)(b)(g)