Birchwood Residential Treatment Centre - Birkenhead

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:

- Staff were suitably skilled and experienced to provide care, treatment and support for clients. Staff received regular supervision, had completed most of their mandatory training, and had had an appraisal.
- There were established referral pathways from the substance misuse teams, the local hospital and GPs. The service was part of a detoxification pathway, and

Summary of findings

clients had access to inpatient/residential or community substance misuse services on discharge. There were clear treatment pathways for clients, the most common being for clients requiring detoxification from alcohol, opiates or stimulants.

- Clients had a comprehensive assessment of their needs from which a recovery plan was developed. The assessment included the client's substance misuse history, their physical and mental health needs and any risks.
- Medication was prescribed by registered nurses who were non-medical prescribers. Clients had their progress monitored throughout their treatment by the use of assessment tools that measured the severity of withdrawal symptoms, and monitoring of their physical observations. Staff were trained and had the necessary medication and equipment to deal with medical emergencies. Medication was stored and managed safely.
- Clients were provided with verbal and written information about the treatment programme, and the restrictions on admission to the service. There were daily community meetings for clients where clients contributed to the day-to-day running of the service. Clients were invited to submit feedback forms to give their views of the service. Clients had access to an advocacy service.
- Incidents, audits and complaints were reviewed locally, and action taken in response. The building and its equipment were clean, safe and well maintained.
- Clients had single rooms, and there was an accessible room with bathroom on the ground floor for clients with limited mobility. The building and its equipment were clean, safe and well maintained.

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

- Recovery plans were not always written in a person centred way and did not include the client's views. All clients were aware of their recovery plans, but they gave mixed views about how involved they had been in the process of developing the plan.
- It was not clear how staff followed the principles of the Mental Capacity Act for clients who may lack capacity to make decisions about their treatment.
- The governance arrangements were in a period of transition. There were two incident report systems – one for Arch Initiatives and one for the NHS trust. The Arch Initiatives system was in transition following the change of ownership in July 2016, and there was not a system for ensuring that incidents were tracked and followed up.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services		See overall summary.

Summary of findings

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Summary of this inspection

Background to Birchwood Residential Treatment Centre - Birkenhead

Birchwood Residential Treatment Centre – Birkenhead provides support and treatment for up to 20 men and women who require drug or alcohol detoxification and stabilisation. The service provides medically managed detoxification by registered nurses, two of whom are non-medical prescribers. The nurses are directly employed by an NHS trust, follow the trust's policies and procedures, and link into the trust's substance misuse service.

Birchwood Residential Treatment Centre - Birkenhead is provided by Arch Initiatives. The ownership of Arch Initiatives changed in July 2016. The provider of the service is still Arch Initiatives, but they are now owned by the Kaleidoscope Project. The Kaleidoscope Project provides a number of services across England and Wales.

There was no registered manager at the time of our inspection, and there was an acting manager in post. This post was due to be recruited to shortly. The service was registered to provide the regulated activity: accommodation for persons who require treatment for substance misuse.

The last inspection of this service was carried out in July 2013. The service was compliant with the five standards inspected.

Our inspection team

The team that inspected the service comprised CQC inspector Rachael Davies (inspection lead) and a second CQC inspector.

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:

- looked at the quality of the physical environment, and observed how staff interacted with clients
- spoke with four of the nine clients in the services at the time of our inspection
- spoke with the manager of the service
- spoke with six other staff
- looked at five care and treatment records, and six medication records, for clients
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

The clients we spoke with were mostly positive about the service. They found the staff helpful and supportive, approachable and caring. Clients felt safe.

Clients were orientated to the service, and understood their treatment programme and the rationale behind the restrictions.

The building was clean and tidy, and clients contributed towards this through allocated roles. Clients were complimentary about the food provided.

Clients had their needs assessed, and a recovery plan was developed from this. There was a mixed response as to how involved clients felt they had been with developing their care plans. Clients discussed their discharge plans with staff.

There were daily community meetings where clients contributed to the daily running of the service. Clients were encouraged to complete feedback forms about the service. Nineteen forms had been submitted during the three months to September 2016. They were all positive, and were complimentary about staff, groups and the detoxification process.

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 areas of good practice:

- The building was clean and safe. The clinic room was well stocked, and equipment was routinely serviced. Staff were trained and had the necessary medication and equipment to respond to medical emergencies. Waste was disposed of appropriately.
- There were suitably skilled and experienced staff to provide care and support for clients. Staff were employed directly by Arch Initiatives and by the NHS trust that jointly provided the service. There were adequate numbers of non-nursing staff, with one vacancy. There were four nursing staff in post, with three vacancies that were being recruited to. Two of the registered nurses were non-medical prescribers. Staff had completed their mandatory training. The service was staffed 24-hours a day and had an on-call manager and non-medical prescriber out of hours.
- Medication was stored and managed safely. Medication was prescribed by two non-medical prescribers, who were both registered nurses. Medication was administered by registered nurses and support workers who had completed a competency-based training.
- Staff were clear about the action to take if a client wanted to leave their treatment programme early.
- All clients had a risk assessment, and a risk management plan developed from this.
- Staff knew how to identify and respond to safeguarding concerns.
- Incidents were reported, investigated and appropriate action was taken to prevent their recurrence.

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

- There were two incident report systems – one for Arch Initiatives and one for the NHS trust. The Arch Initiatives system was in transition following the change of ownership in July 2016, and there was not a system for ensuring that incidents were tracked and followed up.

Are services effective?

We found the following areas of good practice:

Summary of this inspection

- Clients had a comprehensive assessment of their needs from which a recovery plan was developed. The assessment included the client's substance misuse history, their physical and mental health needs and any risks.
- Clients followed a treatment pathway. The three main pathways were for detoxification from alcohol, opiates or stimulants. They followed national guidance. Medication was prescribed by registered nurses who were non-medical prescribers. Clients had their progress monitored throughout their treatment by the use of assessment tools that measured the severity of withdrawal symptoms, and monitoring of their physical observations.
- Clients had their physical healthcare needs assessed and responded to.
- Staff received regular supervision, and had had an appraisal.
- The service had effective links with the NHS trust through which its nursing staff were employed, the local hospital, and the Wirral substance misuse teams.
- Clients were provided with verbal and written information about the treatment programme, and the restrictions on admission to the service. They signed their agreement with the programme.

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

- Recovery plans were not always written in a person centred way and did not include the client's views.
- Capacity assessments were not carried out or recorded.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were positive about the service. They knew what their treatment plan was, and signed their agreement with this. They were treated with dignity and respect by staff.
- Clients were provided with information about the service. They understood the treatment programme, and the rationale behind the restrictions.
- Clients had their healthcare needs assessed and responded to.
- There were daily community meetings for clients where clients contributed to the day-to-day running of the service.

Summary of this inspection

- An external website collated feedback forms submitted by clients, on paper or electronically. In the last three months 19 cards had been submitted, and these contained positive feedback about the staff, groups, and the detoxification process.
- An independent advocate visited the service once a week.

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

- All clients were aware of their recovery plans, but they gave mixed views about how involved they had been in the process of developing the plan.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were admitted to the service within one to three days of referral.
- There were established referral pathways from the substance misuse teams, the local hospital and GPs. The service was part of a detoxification pathway, and clients had access to inpatient/ residential or community substance misuse services on discharge. There were clear treatment pathways for clients, the most common being for clients requiring detoxification from alcohol, opiates or stimulants.
- All clients had single rooms, and there were communal group, lounge and dining facilities. There was access to outdoor space.
- Clients were provided with verbal and written information about the service. This was available in English and Welsh, but interpreting and translation services were provided when necessary.
- There was an accessible bedroom and bathroom for clients with limited mobility. Communal facilities were accessible on the lower and upper ground floors.
- Clients could raise their concerns, and knew how to make a complaint. These were usually raised in one-to-one sessions and in the community meetings.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- The service was effectively managed during a period of transition.

Summary of this inspection

- Incidents, audits and complaints were reviewed locally, and action taken in response.
- Information was collated and submitted to Public Health England through the National Drug Treatment Monitoring System.
- Changes within the service had created uncertainty, but staff were mostly positive about the service.

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

- Birchwood Residential Treatment Centre's governance arrangements for monitoring and managing the service were still being followed, but they were not underpinned by the central structures that had been in place prior to the change in ownership. These were in the process of being reviewed and replaced by the new owners. The existing parallel arrangements for governance between Arch Initiatives and the NHS trust were still in place.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

All clients were presumed to have the capacity to make informed decisions about their care and treatment. Clients had the treatment programme explained to them on admission. They were given a handbook that described what support and treatment was available, and what the restrictions or rules of the service were. The clients signed their agreement with this.

Staff did not carry out an assessment of capacity on clients. Where there had been concerns about capacity, an assessment had not been recorded, but a referral had been made to an appropriate healthcare service.

Training on the Mental Capacity Act was not mandatory for staff employed by Arch Initiatives, but it was and had been completed by staff employed by the NHS trust.

There were no clients at the service subject to the Deprivation of Liberty Safeguards.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

All bedrooms were single occupancy and on gender designated corridors. There was a linking corridor that was used flexibly for all men or all women. The communal bathrooms and toilets were gender specific and adjacent to the bedroom corridors.

The service was mostly clean, tidy and well maintained. We observed that the shower rooms had some mould around the grouting (on the male side), and one of the women's showers had some deteriorating sealant. The receptionist identified issues around the building and reported them to the housing association that owned the building. Maintenance and repairs were carried out by the housing association.

The clinic room and its contents were clean and tidy. Medical equipment was clean and routinely serviced. This included weighing scales, blood glucose monitoring machines and alcometers. There was equipment and medication for use in the event of a medical emergency. For example, a resuscitation trolley, adrenaline, naloxone (for use in opiate overdose) and epipens (for use with severe allergic reactions).

Staff had completed infection control training. An infection control audit had recently been carried out, with some minor issues to be addressed. Sharps bins were available, and clinical waste was disposed of appropriately.

There were appropriate systems for monitoring and maintaining food hygiene standards. Food was stored appropriately, and kitchen cleaning records were up to date. The most recent local authority food hygiene standards visit was in October 2015. The service received its highest rating of 'five' or 'very good'.

Health and safety assessments and routine testing was carried out. For example, a legionella risk assessment had been completed and routine checks of water temperatures were carried out. Fire risk assessments had been carried out within the last year, and there were processes in place for checking fire and emergency equipment. The receptionist carried out routine fire checks of the building.

A former bedroom on the top floor was used as an office and interview room. There was no nurse call point in this room, but staff told us they had a beeper that they gave to staff or clients using the room so they could call for assistance if necessary.

Windows were fitted with limiters to reduce the risk of falls.

There were ligature points around the building, and a ligature audit had not been carried out. However, staff told us their clients were deemed to be at low risk of using ligatures. Staff told us they identified any potential mental health concerns during the pre-assessment process, and used an assessment tool to identify any symptoms of depression. Each client's mental health was assessed as part of the risk assessment completed with clients on admission.

Safe staffing

The acting manager and acting deputy manager were both experienced staff who had worked at the service for several years. There were seven support workers, which included a clinical support worker from the NHS trust. There was one support worker vacancy. The NHS trust provided seven nursing staff – there were four in post: a band 8a, a band 7, and two band 5s. There were three nursing vacancies, which were in the process of being recruited to. The band 8a was the clinical lead for the service, and the band 8a and band 7 were both non-medical prescribers. The nursing staff prescribed and administered the detoxification

programme, and responded to clients' physical healthcare needs. The service used bank and agency staff to cover the nursing vacancies, mostly at night. Staff familiar with the service were used as much as possible.

The service was staffed throughout the day, and there was a nurse and support worker at night, with a manager and non-medical prescriber on call. The manager and deputy manager worked shifts so that there was always someone available. Staff told us the out of hours manager was not often called.

Staff told us that there had been problems with staffing but these were now being resolved. Clients told us that staff were always available, and clients and staff told us that groups were never cancelled because there were not enough staff available.

Support staff included a full-time cook and two kitchen assistants. There was a receptionist and administrator. Domestic and cleaning services were provided by an external agency.

Employment checks were carried out for new staff. These were carried out by Arch Initiatives for non-clinical staff, and the NHS trust for nursing staff.

Most staff had completed their mandatory training. Separate training arrangements were in place for Arch Initiatives and the NHS trust staff. There was a training matrix for Arch Initiatives which was monitored by the manager, and a separate training system for staff employed by the NHS trust which was monitored through the trust's systems. Mandatory training included first aid, safeguarding and the use of the defibrillator in the event of a medical emergency. Staff had completed in-house training on drug and alcohol awareness. The band 7 nurse/non-medical prescriber provided medication training. All staff completed a medication competency pack before they administered medication.

Assessing and managing risk to clients and staff

Medication was stored safely. The clinic room and medication procedures were overseen by registered nurses, but medication was administered by nursing staff and support workers. Two members of staff, one of whom must be a registered nurse, checked and administered controlled drugs. The service had two non-medical prescribers, who were registered nurses. They had both completed the necessary training, and a non-medical prescribing approval to practice form which indicated the categories of medication from the British National Formulary they would prescribe from.

There were detailed patient group directions for the use of medication such as pabrinex (high dose multivitamin), rectal diazepam (to control seizures), and chlordiazepoxide (used in alcohol withdrawal). These were for use by registered nurses only, and were clear about when and how the medication should be used. There were procedures for the administration of over the counter medication, such as paracetamol.

Medication charts were completed correctly and included clients' details and any allergies. The detoxification regimes were prescribed in accordance with the policy and reflected national guidance, such as the National Institute for Health and Care Excellence. Medication was administered following physical observations (such as blood pressure), the relevant withdrawal or symptoms assessment tools, and care and risk management plans.

Medication was provided by two external pharmacies. There were processes for obtaining medication out of hours. On arrival medication was checked by staff. For controlled drugs this included the measuring of liquid medication. Any discrepancies were reported to the pharmacy.

Monthly audits were carried out of medication and controlled drugs. These identified any issues that needed to be addressed, and they were followed up in subsequent months.

Clients had a risk assessment carried out when they were admitted to the service. This included potential physical and mental health risks, and a history of their substance use and previous access to treatment. Risk assessments were at the front of each client's records, and a risk management plan was developed from this. Staff told us that if, for example, they were concerned about a client's mental state, they would carry out regular checks of the client, and ensure this was handed over between shifts. If staff had significant concerns they would take the client to hospital for a mental health assessment.

Substance misuse services

Clients were searched on admission to the service. Restricted items were removed, and there was a zero tolerance approach to the use of drugs and alcohol on the premises. Staff did not carry out invasive searches, but clients were asked to shake out clothing and hairbands.

Clients did not have an individual plan for what action should be taken if they wished to leave treatment early. However, the service had a clear procedure about the action to taken by staff in the event that this occurred. Staff discussed with the client why they wanted to leave, and attempted to address the reasons for this. If the person still wanted to leave the action taken would vary dependent on what substance the client was detoxing from, and where they were in the programme. This included liaising with community services to establish continuation of programme there, and liaising with close friends or family members. For clients who were at high risk of injecting, consideration was given to the use of naloxone, which is a medication that can counteract the effects of a heroin overdose. There were information leaflets for clients and carers in the event that they needed to use naloxone.

All staff had completed safeguarding training. Any safeguarding concerns were highlighted during the referral and assessment process. If potential safeguarding concerns were identified staff raised this with senior staff. If this occurred out of hours they would contact staff on call. If there were urgent safeguarding concerns, staff would contact the local authority directly. Staff gave examples of where they had made safeguarding referrals. They told us that they were not common, as the local authority tended to be involved already if there were concerns. For example, if there were children involved.

Track record on safety

There had been two serious incidents at the service in the twelve months up to 19 July 2016. These involved a fall and an aggressive incident. Each incident had been reviewed and action taken.

Reporting incidents and learning from when things go wrong

Staff reported incidents, which were then followed up by managers. Prior to July 2016 all reports were sent to the chief executive at Arch Initiatives' head office for review. Since 29 July 2016 this process had changed. Staff told us that incidents were still reported, and reviewed and responded to by local managers. The Kaleidoscope Project, who had taken over Arch Initiatives, had their own computer-based system for managing and responding to incidents, and this was due to be implemented at Birchwood. At the time of our inspection, incident information was stored as individual documents on a shared drive.

Incidents that involved nursing staff or were related to clinical issues were reviewed by the lead nurse/ non-medical prescriber. They were recorded in the NHS trust's electronic incident management database, and followed up and managed by the NHS organisation. They were not formally reported to the manager at Birchwood. For example, methadone had been incorrectly recorded. This was addressed by the nursing team, and the times of administration were changed to support correct monitoring and recording.

We saw examples of three incidents. This included a detailed record of the incidents, the immediate action taken, an assessment of the likelihood of the incident happening again, and the level of impact if this occurred. A root cause analysis was completed by the local manager to ascertain the reasons behind the incident, and an action plan was developed from this to prevent a similar incident happening again. Incidents were responded to appropriately. For example, an additional strip of medication was sent with a client's discharge medication. The root cause analysis had identified how this had occurred, and action was taken to prevent this happening again. The medication error was jointly reported through Arch Initiative's and the NHS trust's incident reporting processes.

Information about and learning from incidents was shared with staff through handovers and emails. Staff records showed that debriefs had occurred with staff following incidents.

Accidents were recorded in an accident book, which was made up of loose sheets of paper. Over the last 12 months there had been eight accidents recorded. Six of these were falls, which were relatively minor and had not resulted in significant injury. An ambulance had been called for a client who was unwell, and another client had absconded. There were no particular themes or recurring events.

Duty of candour

Substance misuse services

Staff understood their responsibilities with regards to the duty of candour. There were no recorded incidents of a level that met the criteria for a formal apology. Staff were open with clients about their care and treatment.

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

Assessment of needs and planning of care

New clients were orientated to the service, which included explaining the treatment programme and restrictions. A support worker carried out the initial assessment, which included physical observations and recording treatment assessment outcome profile information (often referred to as TOPS) which is centrally reported to Public Health England. An assessment of risk was also completed. Clients had an initial risk assessment, usually based on referral information, but a fuller assessment and more through risk management plan was then developed.

Clients were assessed by the non-medical prescribers, who also recorded a detailed history and assessment. This included the clients' physical and mental health, addiction history and symptoms, and any related healthcare issues such as blackouts or tremors. Medication was prescribed for the client's detoxification programme, which included managing withdrawal symptoms. Assessment tools were used that were tailored to the specific drug the client was being detoxed from. Other assessment tools were used to monitor other common symptoms such as depression and anxiety.

We looked at five care and treatment records. They contained detailed information about each client and a recovery plan. However, the recovery plans were not written in a person-centred way and did not include the client's views.

There were three main treatment pathways that covered detoxification from alcohol, opiates (such as heroin), and stimulants (such as amphetamines and cocaine). The medication prescribed and length of stay varied according to the client pathway.

Alcohol detoxification lasted a maximum of seven days. Assessment tools were used to monitor the client's symptoms and withdrawal, such as the modified clinical institute withdrawal assessment for alcohol. They used the modified rather than the full version of the tool, so that it was consistent with the local NHS hospital where clients were frequently referred from. Physical observations were also taken and monitored, using charts that indicated when concerns should be reported to the nursing staff. After the detoxification clients would be discharged into the community, and followed up by the community substance misuse team, and/or referred into alcohol support services in the community.

Stabilisation on an opiate programme (methadone) usually took seven to 14 days. This could be extended slightly dependent on the needs of the client. Clients were discharged back to their local substance misuse services.

An opiate detoxification programme usually took between three and four weeks. This was influenced by the substances the client was using on admission, and whether they were going to an inpatient/residential or community recovery and rehabilitation services on discharge. The subjective opiate withdrawal scale was used to ensure that clients received the correct amount of medication.

A stimulant detoxification programme typically took five to seven days, dependent on the drug and how much and how long the person had been using it. The prescribing regime started at a standard dose, and reduction took place over the following week.

Clients had a physical healthcare examination carried out on admission, with follow up if required. Clients told us they had their physical healthcare needs assessed. Clients remained registered with their own GP whilst they were at the service. If a client was not from the Wirral area, or their GP was not local, the non-medical prescribers reviewed their care, or they could be taken to the walk-in centre. The non-medical prescribers dealt with physical healthcare problems. The non-medical prescribers told us they did not routinely initiate new medication, but they may do so if required. The non-medical prescribers could prescribe medication that had already been initiated by the client's GP. For example, if a client needed used an asthma inhaler.

There was a recovery group programme. There were two groups each day as part of a two-weekly rolling programme. These included relapse prevention, coping skills, problem solving and alcohol awareness. There were activities at weekends such as quizzes, and families visited on Sundays. Mutual aid groups were provided solely for the clients in the service. There were three a week, one each for

alcohol, cocaine and narcotics. Staff told us that there was some sharing of experiences by clients, but the groups were primarily for information and a member of staff sat in on them.

Best practice in treatment and care

The service followed national guidance on the management of alcohol and substance misuse, and prescribing medication for their detoxification programmes. They reflected the Department of Health's 'Drug misuse and dependence: UK guidelines on clinical management' (often referred to as the 'orange book'), and the National Institute for Health and Care Excellence clinical guideline 100 'Alcohol-use disorders: diagnosis and management of physical complications', and clinical guideline 115 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence'.

Assessment tools were used for monitoring withdrawal symptoms and making necessary adjustments as a result. This included the modified clinical institute withdrawal assessment for alcohol, and the subjective opioid withdrawal scale. Other assessment tools were used to monitor other symptoms. For example, clients may experience symptoms of depression or anxiety during the withdrawal process. The patient health questionnaire-9 was used to monitor symptoms of depression and the generalised anxiety disorder-7 tool was used to monitor symptoms of anxiety.

The service had policies about the use of naloxone by staff, and when it should be provided to clients. Naloxone is used as an emergency medication to counteract the effects of opiate overdose. User-friendly information about the use and administration of naloxone was available for clients and their families. This included information about the need to contact emergency services, in addition to administering naloxone.

Skilled staff to deliver care

The service had a mix of support workers and registered nurses. They worked together but had specific roles within the service.

There was a therapeutic recovery worker, who carried out some of the comprehensive assessments, one-to-one sessions and two groups each day. There was a trainee substance misuse worker on secondment who completed the care plans, assessments, one-to-one sessions and aftercare plans. The service had a dedicated group facilitator.

There was no direct medical input to the service. Prescribing was carried out by independent non-medical prescribers, who were both qualified nurses (band 8a and band 7). The non-medical prescribers had carried out certified training in this, and in addition to their nursing qualifications had additional graduate and post-graduate training in relevant subjects.

At night, there were at least two staff on duty – a registered nurse and a support worker. Staff worked shifts, and this included the manager, deputy manager and non-medical prescribers. A manager and one of the non-medical prescribers were on call outside the main working hours. They primarily provided phone support, but visited the service when necessary.

There was a cascade system for supervision of nursing staff. The most senior nurse (band 8a) received supervision through the NHS trust. Support workers and other non-nursing staff received supervision from the deputy manager every four to eight weeks.

Nursing staff had had an appraisal within the last 12 months, which used the NHS trust's appraisal process. Most Arch Initiatives staff had had an appraisal in September 2015. These would usually take place once a year. However, they had intentionally been delayed so they could be incorporated into the new owners appraisal cycle, which started in December and January each year.

There was an induction programme for new staff.

Multidisciplinary and inter-agency team work

The service worked closely with substance misuse services in Wirral. Staff from these services visited Birchwood and determined appropriate follow up and support for clients once they were discharged. Non-nursing staff were employed by Arch Initiatives, and nursing staff which included the non-medical prescribers were employed by an NHS trust. The services followed the NHS trust's policies in clinical practice, and the non-medical prescribers met regularly with colleagues in the trust's substance misuse services.

A verbal and written handover was carried out between staff at the change of each shift. The handover file

contained a summary of key information about each client, and included details of any tests that were required including physical health observations and drug tests. It identified any other issues with clients, or with the running of the service. For example staffing or any repairs.

Good practice in applying the MCA

All clients were presumed to have capacity to make decisions about their care, and to consent to the treatment programme and its restrictions. Clients had not had an assessment of their capacity. In four of the five records we looked at there were no apparent capacity issues identified. However, in one record the person was identified as having a cognitive impairment, but had not had a capacity assessment. Staff described the action they had taken with regards to a client who had had cognitive impairment, which included a referral to an appropriate healthcare service.

Training on the Mental Capacity Act was not mandatory for Arch Initiative's staff. However, staff were able to describe a basic capacity assessment, and were clear that about each client's ability to consent to their treatment. If clients were intoxicated when they arrived at the service, staff waited for them to sober up before starting the orientation and assessment process. Staff employed by the NHS trust had completed training on the Mental Capacity Act.

All clients had signed their terms of treatment agreement. This included their understanding of the restrictions within the service, such as limited access to phones, and any clients leaving the building agreed to be escorted by staff.

There were no clients at the service subject to Deprivation of Liberty Safeguards.

Equality and human rights

There was an equality and diversity policy. Equality and diversity training was mandatory, and all staff had completed this within the last year.

The service had a list of rules and restrictions that clients were expected to abide with during their stay. These were in the clients' handbook that was given to and explained to clients on admission. The restrictions aimed to encourage clients to engage with the programme, and to minimise access to drugs and alcohol during their treatment programme. The rules applied to all clients, but there was flexibility if the reason was justified.

Management of transition arrangements, referral and discharge

The service accepted referrals from anywhere in the country, but most clients were from the local area (Wirral) and were admitted from the local NHS hospital and/or Wirral substance misuse services.

Clients were usually admitted for a specific detoxification programme, for the length of time specified in the pathway. There were detoxification pathways for alcohol, opiates, and stimulants such as amphetamines and cocaine. The detoxification programme was usually one part of the pathway within Wirral, and clients had access to inpatient or community rehabilitation and recovery services that they went to after discharge. This was supported by a member of staff from Wirral substance misuse services who routinely visited Birchwood to review the discharge plans for clients. The substance misuse team ultimately decided how long the detoxification would last and when the client would be discharged, although Birchwood staff could advise if they believed an individual client's programme needed to be extended.

Are substance misuse services caring?

Kindness, dignity, respect and support

Clients were mostly positive about the service. They told us the staff were helpful and supportive; they were always available and were approachable and not dismissive. They knocked on clients' bedroom doors before entering, and were respectful and polite. Clients told us they thought staff were caring and put clients first.

Clients felt safe in the service. The clients we spoke with told us they had not experienced any aggressive behaviour towards themselves, and were aware that the clients' handbook said that any clients who were aggressive would be discharged.

Clients were aware of the restrictions, and understood the rationale behind them. They understood the reason for clients being searched on admission, but felt this was applied inconsistently by staff. When searches were carried out, they were by a person of the same sex and in a private room. Some clients thought the restrictions could be adapted for clients who had been in the period for a long period of time, for example over 28 days.

Substance misuse services

Clients told us that the building was always clean, tidy and maintained. They said they had allocated roles that contributed towards this. Clients were complimentary about the food provided.

The involvement of clients in the care they receive

Staff explained the treatment programme to clients, and the clients we spoke with said they had understood this. Clients were provided with a service user handbook when they were admitted. This included a detox handbook and a reflection diary for use throughout the programme. Clients were positive about the groups provided.

Clients told us they had had their physical healthcare needs assessed, and a risk assessment carried out. They discussed discharge arrangements with staff, and their ongoing support after discharge. They discussed exit plans with staff. Some clients told us they felt involved in their care plan and that the support was tailored to their needs. Other clients told us they were not involved in the development of their treatment programme. They didn't have a copy of their care plan, but could request it if they wanted it. The care plan in the service linked into their community care plan.

Clients said they were asked if they wanted their friends and families involved when they were admitted to the service.

There were daily community meetings during the week where clients could make comments and raise concerns about the day-to-day running of the service. This included reporting and feedback on any maintenance issues, and arranging appointments and visits.

Clients were aware of feedback forms that they could use to provide feedback about the service. Clients were asked for feedback, which they could do through review cards or electronically. When review cards were completed these were fed into an external website which collated the information. Eighty five per cent of feedback was submitted through paper forms. The service had had 397 entries, though it was not clear what timescale this was over. The most recent entry was in September 2016. During the three months prior to the inspection there had been 19 comment cards completed. These all contained positive feedback, and were complimentary about staff, groups and the detoxification process.

An independent advocacy service visited the service once a week.

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

Access and discharge

The typical length of stay varied from three days to four weeks. Alcohol programmes typically lasted a few days, whilst clients detoxifying from opiates usually took three to four weeks. The service accepted referrals from across the country, but most were from the North West, and particularly the local area (the Wirral).

Clients were referred to the service by their GP, the local hospital or the substance misuse team. Clients referred to the service were usually admitted on the next available weekday, so would have to wait no more than two to three days. Some clients were seen at the local hospital, and admitted to Birchwood the same day. From July to September 2016, the service had admitted 134 clients, and of these 127 had successfully completed their detoxification programme. The service knew why the remaining seven episodes (involving six clients) had not been completed, and the action they had taken to address this.

The service admitted people over 18 years of age, and most clients were in the 25-55 years age range. The service would admit a maximum of two people aged over 65.

There were no reported delays in discharging clients. Clients were admitted to Birchwood as part of a pathway of care, and were discharged to an inpatient/residential service, or to the community with support from and access to community substance misuse services.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms to support treatment and care. These included group, lounge and dining rooms, laundry facilities and a therapy room. There was a garden with seats and an outdoor smoking area. There was a staffed reception area. There was a well-equipped clinic room where medication was administered and clinical procedures were carried out, such as changing dressings.

Clients were positive about the food, which was prepared and cooked by the service. Clients had access to hot and cold drinks whenever they wished.

There were a number of rules or blanket restrictions that clients were expected to comply with during their stay. These were explained to clients as part of the admission process. Clients had to be up by 7am each day, and there were set times for meals. Clients told us that they found this a struggle sometimes, but acknowledged that the rationale behind this was to encourage a routine.

Other restrictive practices included that clients must not go into each other's rooms, they were not allowed mobiles, laptops or phones. They had one outgoing call a day, and one visit per week. There was flexibility in this, for example if relatives were unable to attend, or if clients needed to make non-personal calls during office hours. Clients were not allowed to go out unless escorted by a member of staff, and must not wear sunglasses or hats in the house, or put their feet on the furniture. The manager told us that these restrictions were similar to other units. The rules encouraged clients to respect the service and other clients, and to engage with the process rather than isolate themselves from others. Staff also wanted to support clients to break the cycle of substance misuse, and believed that access to phones and unescorted visits tempted clients back into habits of drug taking. Clients were at the service for a short period of time, and were taking medication and managing withdrawals symptoms which required regular observation and monitoring by staff.

Meeting the needs of all clients

There was an accessible bedroom for clients with limited mobility. A room on the ground floor was wheelchair accessible and had a height adjustable bed and an accessible ensuite bathroom. The upper floors were only accessible via stairs, but the communal facilities were on the upper and lower ground floors. There was a lift between the upper and lower ground floors.

Information leaflets were provided in English and Welsh, but no other languages. Staff told us that they had brought in interpreters when required. For example when they had had clients who were Polish, or were deaf.

There was a rolling menu of food with alternatives available. The kitchen staff had a list of clients' dietary requirements. This included for clients who had health needs such as diabetes, cirrhosis of the liver, and required a gluten-free diet. Suitable food was accessible for clients with cultural or religious needs. For example if clients required vegetarian or halal food.

Listening to and learning from concerns and complaints

There was a process for dealing with complaints. There had been one formal complaint in the previous 12 months, which had been resolved. Clients told us they knew how to make a complaint and would feel confident to do so. Clients were able to raise their concerns through 1-1 sessions with staff, groups sessions and community meetings.

Complaints about clinical issues, medication or the nursing staff would go to the manager at Birchwood, and to the NHS trust. Complaints about non-clinical issues would be dealt with by the manager at Birchwood, and through the Arch Initiatives complaints process. Learning from complaints would be communicated to staff through supervision, at handovers, and in team meetings.

Are substance misuse services well-led?

Vision and values

The manager told us that the vision and values of the service were under review following the change of ownership, but the current vision and values were a mixture of those of Arch Initiatives and the NHS trust. These were courage, competency, compassion, care and commitment. They aimed to support people with substance misuse and transformed lives and communities. Staff were broadly familiar with the vision and values.

Good governance

Following the change of ownership of Arch Initiatives at the end of July 2016 the service was in a transitional period. Staff and managers were continuing to provide a service, and any incidents and complaints were reported and investigated and responded to appropriately. There were joint processes running in parallel between the provider and the NHS trust. The NHS trust procedures continued to be followed for issues that were under the remit of the nursing staff and included all clinical governance. However, the governance and monitoring structures for Arch Initiatives were in the process of being reviewed by the new

owners with a view to incorporating Birchwood into its own systems and policies. Information that had formerly been held centrally by Arch initiatives, such as recruitment information and resolved incidents and complaints, had been transferred to the central office of the new owners. This made it temporarily inaccessible to managers at Birchwood.

There were ongoing meetings between the new owners and the NHS trust to review the model of care, and to ensure there were robust working arrangements. Strategy meetings were planned to incorporate Arch Initiative's policies and procedures under the umbrella of their new owners.

Governance appeared to work, but there were separate streams for Arch Initiatives and the NHS trust. Some of the governance information – for example recruitment information for staff working in the service for some time, and old incident forms were not readily accessible. They were paper and electronic based and we were informed that they had been transferred to the new central office. The transition of systems and processes was still under review.

The service collated and submitted data to the National Drug Treatment Monitoring System. All drug treatment agencies must provide a basic level of information to Public Health England each month, through the National Drug Treatment Monitoring System. The service submitted 'Treatment Outcomes Profile Plus' data, often referred to as 'TOPs'. This was a summary of standardised information about clients who used substance misuse services. The information measured the progress of individual clients, and built a national benchmark of how services were impacting on the lives of people within drug and alcohol services.

Leadership, morale and staff engagement

At the time of our inspection, there was no registered manager, but an experienced deputy manager was the interim manager of the service. Staff employed by Arch Initiatives and the registered nurses employed by the NHS trust, worked together and were clear about each other's roles and responsibilities.

There had been uncertainty within the service, staff leaving and a hold on recruitment of nurses, which had led to staffing issues. The service was still in transition following the change of ownership at the end of July 2016, but uncertainty about the future of the service had been resolved and recruitment was underway. The staff we spoke with were positive about the service, and felt able to raise concerns. They were aware of how to escalate these if necessary.

Commitment to quality improvement and innovation

The lead non-medical prescriber and supervisor, who was a band 8a registered nurse, reviewed any changes in practice such as changes to prescribing guidelines. The registered nurses were part of the NHS trust's substance misuse team, and worked with them regarding new policies and guidelines for the treatment of substance misuse.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there are clear processes for reporting, following up and tracking all incidents.
- The provider should ensure that there are robust arrangements in place for carrying out and recording capacity assessments, for clients who may lack the capacity to make decisions about their treatment.
- The provider should ensure that clients are involved as much as possible in the development of their recovery plans, so that they are person-centred and include the client's views.
- The provider should ensure there are robust governance arrangements in place that incorporate the exiting service, the new owners, and the NHS trust.