

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

Ratings

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

Overall summary

We rated this service as good because:

- The service provided safe care. The clinical premises where clients were seen were safe and clean. The service had enough staff. Staff assessed and managed risk well and followed good practice with respect to safeguarding.

Summary of findings

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and relevant services outside the organisation.
- Staff treated clients with compassion and kindness, and understood the individual needs of clients. They actively involved clients in decisions and care planning.
- The service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.
- The service was well led, and the governance processes ensured that its procedures ran smoothly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good 	See main body of the report.

Summary of findings

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Good 

Birchwood Residential Treatment Centre - Birkenhead

Services we looked at:

Substance misuse services.

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.

Birchwood Residential Treatment Centre - Birkenhead is provided by the Kaleidoscope Project, a not for profit organisation. The service was formerly provided by Arch Initiatives, and the Kaleidoscope Project took over the ownership of Arch Initiatives in July 2016. The Kaleidoscope Project registered as the provider of Birchwood Residential Treatment Centre – Birkenhead in November 2018. This is the first time the service has been inspection since this registration.

The service is registered to provide the regulated activities: accommodation for persons who require treatment for substance misuse; and treatment of disease, disorder or injury. The service has a registered manager.

Care in the service is funded by specific contracts with local authorities, one-off purchases from individual health care organisations and local authorities, and individuals purchasing their own treatment.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a nurse.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the environment and observed how staff were caring for clients
- spoke with five clients who were using the service
- spoke with the registered manager
- spoke with eight other staff members
- attended and observed an assessment, community meeting and activity session
- collected feedback from 12 clients, seven staff or volunteers, and one carer using comment cards
- looked at three care and treatment records of clients including prescription charts
- reviewed how medication was managed in this service
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

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

Clients' feedback was very positive about the service. Clients told us that staff were very supportive, and treated them with kindness and compassion. The interactions we observed between staff and clients, and in group sessions, was positive.

Clients signed their agreement to the terms of their treatment on admission, and developed their risk and recovery care plans with staff. Clients were provided with copies of their recovery plans. This included on discharge, as the plan was considered part of their continuing recovery during and after treatment in the service.

All clients were given a feedback form on discharge. We saw five feedback forms which were very positive. Common feedback was that staff went "above and beyond" in providing 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 rated this service as good because:

- The service had enough nursing and medical staff, who knew the clients and received basic training to keep them safe from avoidable harm.
- Staff screened clients before admission and only admitted them if it was safe to do so. They assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each client's physical health.
- The service had a good track record on safety. The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.
- Clinical premises

However

- Although most areas of the building were clean and maintained, the showers had black and orange marks in the sealant and grout, and there were residual damp stains on some of the ceilings.

Good



Are services effective?

We rated this service as good because:

- Staff completed comprehensive assessments with clients on admission to the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Good



Summary of this inspection

- Staff provided a range of care and treatment interventions suitable for the client group and consistent with national guidance on best practice. They ensured that clients had good access to physical healthcare and supported clients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The teams included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff supported clients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2015 and knew what to do if a client's capacity to make decisions about their care might be impaired.

Are services caring?

We rated this service as good because:

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

Good



Are services responsive?

We rated this service as good because:

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

Good



Summary of this inspection

- The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

We rated this service as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff collected and analysed data about outcomes and performance.

Good



Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff had received training on, understood, and had access to the service's policies on the Mental Capacity Act and the Deprivation of Liberty Safeguards.

All clients had their capacity to consent to treatment assessed on admission. If there were concerns about a client's ability to consent to the admission, this would be identified as part of the assessment process. All clients

were given clear information about the service and what to expect. Clients signed a terms of treatment form to confirm that they understood and accepted their admission to the service.






In the year up to the inspection there had been two Deprivation of Liberty Safeguards applications for clients in the service. These were for clients who did not have the capacity to make the decision to stay at the service. A decision had been made, in discussion with other agencies, that it was in each client's best interest to stay at and receive treatment at the service.

Overview of ratings

Our ratings for this location are:

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

Substance misuse services

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

Are substance misuse services safe?

Good 

Safe and clean environment

All premises were safe, clean, well maintained and fit for purpose. The building was clean and comfortable, with rooms for clients to participate in activities, eat, sleep and relax. Most of the building was clean and well maintained. However, the showers had black and orange marks in the sealant and grout, and the shower mats looked dirty. There were water marks on the ceiling from previous leaks. The provider told us they were waiting for the landlord to address these. Staff adhered to infection control principles, and there were sufficient handwashing sinks and personal protective equipment. Electrical equipment was checked by a member of staff who was trained to test portable appliances.

Ligature audits had been carried out, and action had been taken where identified as necessary. Clients who were identified as being at significant risk of harm, were discussed prior to admission to determine if the service could meet their needs. The use of window restrictors and how wide windows opened had been reviewed throughout the building.

A new call bell system had been fitted throughout the building. This covered all areas except four bedrooms on the top floor. These rooms were currently being used as an office, a prayer room and two staff bedrooms. Staff told us that they could potentially be used for client bedrooms, but would be risk assessed beforehand.

All clients had individual rooms, most with separate toilets, baths and showers. Three bedrooms on the ground floor had ensuite bathrooms and were intended for clients who required higher levels of observation or had physical healthcare needs. The building had a male side and a female side that contained bedrooms and bathrooms. The communal areas were mixed, and the three bedrooms on the ground floor could be allocated to either gender. There was a gender neutral toilet on the ground floor. The prayer room was on the women's side of the building. Staff told us that if a man wanted to use this they would be escorted by a member of staff.

The kitchen was clean and all the necessary checks were carried out. There was appropriate equipment, signage and personal protective equipment available. Food was stored correctly.

Safe staffing

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

At the time of inspection, the service had three registered nurses in post and two nurse vacancies, which were being covered by agency nurses who knew the service. In addition, the registered manager was a registered nurse, and there was a non-medical prescriber. When the non-medical prescriber was on leave or absent, this was covered by a bank non-medical prescriber who worked regularly in the service. There were nine detox practitioners in post, with no vacancies. Additional staff working in the service included an engagement worker, kitchen and domestic staff, a driver and volunteers.

Substance misuse services

In the year up to 13 June 2019 the overall sickness rate was 3.2%, which included long term sickness. Without long term sickness the overall sickness rate was 1.9%.

In the six month period up to 13 June 2019 there were 75 shifts filled by bank or agency staff, and no shifts that had not been covered. The registered manager had presented a business case to increase the number of detox practitioners, and this had been accepted.

There was adequate medical cover. Most prescribing was carried out by the non-medical prescriber. A GP with a special interest in substance misuse visited the service once a week to provide GP services, and outside this clients could contact the GP practice. The Kaleidoscope Project's clinical director visited the service each month, and carried out clinical audits, provided clinical supervision for the non-medical prescriber, and attended clinical governance meetings. The clinical director did not routinely see clients, but was available on call for advice. The service had access to consultant neurologists who were national specialists in alcohol related brain injuries. Assessments were typically carried out within one to two weeks of referral.

Staff were up to date with their mandatory training. Mandatory training included statutory training, such as fire safety, health and safety awareness and safeguarding. There was specific training for working in the service such as about detoxification, boundaries, and working with challenging behaviour.

Assessing and managing risk to clients and staff

Staff screened clients before admission and only admitted them if it was safe to do so. They assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health. Safety planning was an integral part of recovery plans.

Clients were only admitted once a GP summary and recent blood test results had been received. The risks presented by the client, usually in relation to their physical and sometimes mental health, were considered. If on admission there were significant concerns about the person's health appropriate action was taken, such as transfer to an emergency department. Staff were experienced at monitoring clients' physical health. This included monitoring for the risk of seizures, and staff were

familiar with the policy for identifying and managing seizures. If a client was deemed to be at particular risk, they would have a member of staff with them at all times or be checked upon regularly.

All clients had a risk assessment carried out, and a risk management plan was developed with the client in response to this. Clients were made aware of the risks of continued substance misuse, and also of the effects of stopping use, and the experience of detoxification.

Staff had basic life support training to respond to a medical emergency, which included an automatic external defibrillator. The service's policy was to call an ambulance and initiate basic life support. There was a grab bag with emergency equipment, which included adrenaline and naloxone (a temporary antidote to opiate overdose). Clients at risk of seizures, a potential risk during alcohol withdrawal, were prescribed anti-seizure medication to use if required.

The service employed a driver to escort clients to and from the service. This was part of the contract with some commissioners, as the service was at a distance from the client's home area. There was a policy and risk assessment about the use of transport, and whether the driver was a lone worker or had an additional member of staff with them. This included a risk assessment of potential risks such as of seizure, self-harm, and sexual issues.

The service had restrictions in place that clients agreed to on admission. These included no drugs or alcohol in the service, and being escorted by a member of staff when going outside the unit. Staff told us that the restrictions had been reviewed, in discussion with clients, and several outdated restrictions had been removed. For example, there had been restrictions on the supply of caffeinated drinks, and clients had not been allowed televisions or DVD players in their rooms. These restrictions had now been lifted. Restrictions were routinely discussed in community meetings. The clients we spoke with felt that the restrictions in place were reasonable and they understood the rationale behind them.

Safeguarding

Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Substance misuse services

Staff had completed safeguarding training, and knew how to identify and report safeguarding concerns, and how to access advice and support. The service had a safeguarding lead, but any member of staff could report a safeguarding concern. The service had links with the local authority safeguarding team. Staff gave examples of safeguarding concerns that had been identified, reported and responded to appropriately. This included risks to clients themselves, or to other adults and children outside the service. Staff had worked with the client where possible, social and health care services, and the police to address these concerns.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Each client had an electronic and paper care record. The service had an electronic care records system in which most information was recorded, including care plans and daily care records. Some information was still on paper, but this was scanned onto the electronic records system. Paper records included prescription charts, GP summaries and blood results, and signed terms of treatment. Staff were clear about where to record information and where it was stored.

All staff had access to the care records. A handover document was emailed to all staff at the service each day, and to senior managers in the Kaleidoscope Project.

Medicines management

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

Medicines were stored securely. Nursing staff carried out a weekly audit of medicines including storage and administration, and the clinical director carried out a monthly audit of medicine-related issues. These included the safe and secure management and administration of controlled drugs and drugs liable to be misused. Medicine was supplied by an external pharmacy. Any unused or unwanted medicine was disposed of through the external pharmacy.

All six medicine charts in use at the time of inspection were reviewed, and no errors were seen. All charts contained a photo of the client, and noted any allergies or sensitivities.

The non-medical prescriber carried out most of the prescribing, following set protocols and regimes. These included standard, enhanced, and elderly/frail presentation protocols. Within these there was flexibility to consider individual needs and adaptations to accommodate this where possible. The non-medical prescriber was supervised by the clinical director who they could contact for advice. Medicines were also prescribed by the visiting GP.

The service's medicines policies reflected national guidance, and prescribing plans followed these.

Track record on safety

The service had a good track record on safety. The service reported incidents but had had no serious incidents in the twelve months up to this inspection.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave clients honest information and suitable support.

The service had an electronic incident reporting system that staff were familiar with. Staff had received training in and understood how to report an incident and the duty of candour. Incidents were reviewed by managers, and within the wider Kaleidoscope group. A quarterly report was compiled to identify any themes or trends, and to ensure that actions were carried out.

The service had made changes following incidents. For example, an increase in clients with mental health problems and self-harming behaviour had led to a ligature policy/audit being carried out, and staff received training in how to work with these needs more effectively. Staff were familiar with monitoring clients at risk of seizures, and had responded positively to medical emergencies, but it was identified that it would be beneficial to have oxygen onsite, and a procedure and training was developed for this.

Substance misuse services

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

Good 

Assessment of needs and planning of care

Staff completed comprehensive assessments with clients on admission to the service. They worked with clients to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.

Clients referred to the service were usually assessed through a phonecall, following completion of referral information. If staff were unsure about whether they could meet the needs of the client, they would carry out a face to face assessment before making a decision. The service did not accept clients without a GP summary and recent blood tests. This was typically within the last three months, but more recently for clients with significant physical health concerns.

The service has registered nurses onsite at all times but not medical staff, so the screening process ensured that clients were physically well enough for the service. The screening process was usually effective, but there had been occasions when the client was reviewed on admission and found to be too unwell. In these circumstances the client was taken immediately to the local emergency department.

Clients were assessed by the non-medical prescriber on admission. This included an assessment of their physical and mental health, and their addiction history and social issues. The treatment plan was discussed as part of the assessment process, and the client's consent was discussed and documented. Risk and recovery care plans were developed as part of the assessment in consultation with the client.

We reviewed three care records. These included all the necessary information, and were individualised and recovery focused. The care records included up to date risk assessments, detailed assessments of substance use and previous access to treatment, harm reduction advice and

assessment of motivation to change, assessment of capacity and consent to treatment, and risk and recovery plans. Clients' physical health was monitored and responded to through the detoxification process.

The detoxification prescribing rationale was with the treatment plan. There was a regular medical and prescribing regime review. The non-medical prescriber carried out most of the reviews, with input from medical staff when required.

Clients had care plans for an unexpected exit from service. Staff were aware of the policy on the action to take if a client wished to leave the service before their treatment had finished. Staff would discuss with the client why they wanted to leave and the potential risks, and try and discourage them from doing so. If there were particular risks for example it was at night and there was no transport, they would not stop the client from leaving, but would try to persuade them to wait until the following day. Staff would inform family members and relevant agencies.

Best practice in treatment and care

Staff provided a range of treatment and care for clients based on national guidance and best practice. They ensured that clients had good access to physical healthcare and supported them to live healthier lives.

Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The service provided detoxification programmes, and had clinical guidelines for these which were in line with national guidance. When the prescribing deviated from national guidelines, the rationale for this was documented.

The treatment outcomes profile form was completed and submitted to Public Health England on admission, during (if required) and at the end of treatment. Rating scales and tools were used to monitor each client's progress and symptoms. This included the severity of alcohol dependence questionnaire and the Clinical Institute withdrawal assessment of alcohol scale.

Staff had received training in recognised psychosocial tools for working with clients with an addiction. Two groups were provided in the service each day during the week. The group programme was a mixture of specific addiction work,

Substance misuse services

general psychosocial interventions, and life skills and general distraction activities. There was a daily community meeting during which the plan for the day was discussed, and any concerns raised.

The service was not commissioned to provide blood borne virus testing for clients. However, they supported clients who may have already been tested and get the results whilst they were at the service. Clients at the service received seasonal flu vaccinations.

Staff were trained in the use of naloxone (an antidote to opiate overdose). They were not contracted to provide naloxone or training in its use to clients and their families. However, this was provided if individuals requested it or there was a perceived risk on discharge.

Monitoring and comparing treatment outcomes

Care and recovery plans were regularly reviewed with the client. Staff completed treatment outcome profile information for each client, and this was submitted to Public Health England.

Skilled staff to deliver care

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

New staff received a two week induction which included mandatory training and shadowing experienced staff. They were required to pass a competency assessment before they could work with clients.

Staff received regular supervision. The service's target was six weekly, and this was usually met. Staff used a standard supervision template which included wellbeing, reflection on the previous supervision, general performance, and a review of clinical notes, new clinic policies, training, and reflection on a recent client episode or incident. As part of the wellbeing section, staff may discuss their own recovery if this was relevant.

All staff who had been in the service for more than a year had completed an appraisal. This included identifying their learning and development needs. Staff were up to date with their mandatory training.

The service followed standard recruitment procedures which included seeking references and occupational health checks for all potential staff and volunteers. All staff and volunteers had a disclosure and barring service check before they started working in the service. The interview process included discussion of the potential staff member's experience of working in substance misuse services, and of using services and the support required for their own recovery journey.

There were no psychology staff at the service. Some of the staff were trained counsellors, following training in previous employment.

The service had a clear process for managing staff performance concerns, which it had implemented effectively.

The service employed four volunteers at the time of our inspection. These were people with previous experience of substance misuse services, who had been abstinent for at least six months. Volunteers underwent the same recruitment checks and received the same mandatory training as employed staff.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit clients. They supported each other to make sure clients had no gaps in their care. The team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

A daily handover was emailed to all staff. A daily allocation sheet was also sent which included plans for the day such as client one-to-ones and reviews, admissions and discharges, security checks, issues that needed following up such as housing, and staff breaks.

Staff from the service visited the Wirral community substance misuse once a week, so that they could introduce themselves to clients who will or may come to the service for detoxification.

The service provided a detoxification programme. This involved some recovery work, such as groups. However, the

Substance misuse services

pathway for many clients was to complete the detoxification programme at this service, and then move on to a recovery/rehabilitation programme within their own area. This was often identified prior to admission. Some clients did not have this level of support, and the service worked with statutory and voluntary services (such as housing and social services), to facilitate a client's discharge.

The service attended the monthly frequent attenders meeting in Wirral. This involved a number of local agencies, and aimed to provide a more effective outcome for people who regularly attended the emergency department, and ultimately reduce the number of times they presented there. This was not exclusively about people who misused substances, but this was relevant for a number of clients. Birchwood Residential Treatment Centre was part of the team, and had provided support for a number of clients. This included staff at the service being 'on call' for support for some clients, and working with complex clients at the service. The reasons are complex, but notes from the meeting showed that working together had produced a significant reduction in the number of alcohol related admissions in Wirral.

The service had weekly mutual aid groups (when relevant) for alcoholics anonymous, cocaine anonymous, narcotics anonymous and smart recovery. These were only for clients in the service, and were led by an external facilitator from the local community substance misuse service.

Adherence to the MHA and the MHA Code of Practice

The service was not registered to accept clients detained under the Mental Health Act. Staff knew who to contact if they were concerned about a client's mental health.

Good practice in applying the MCA

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

Staff had received training on, understood, and had access to the service's policies on the Mental Capacity Act and the Deprivation of Liberty Safeguards.

All clients had their capacity to consent to treatment assessed on admission. If there were concerns about a client's ability to consent to the admission, this would be identified as part of the assessment process. All clients were given clear information about the service and what to expect. Clients signed a terms of treatment form to confirm that they understood and accepted their admission to the service.

In the year up to the inspection there had been two Deprivation of Liberty Safeguards applications for clients in the service. These were for clients who did not have the capacity to make the decision to stay at the service. A decision had been made, in discussion with other agencies, that it was in each client's best interest to stay at and receive treatment at the service.

Are substance misuse services caring?

Good 

Kindness, privacy, dignity, respect, compassion and support

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

Clients' feedback was very positive about the service. Clients told us that staff were very supportive, and treated them with kindness and compassion. The interactions we observed between staff and clients, and in group sessions, was positive.

All clients received a welcome file when they were admitted to the service. The assessment process included an introduction to the service, and an explanation of the detoxification process. The clients' welcome file included a detoxification handbook, client handbook, and information about how to make a complaint or compliment.

Clients signed their agreement to the terms of their treatment on admission, and developed their care and risk management plan with staff.

Involvement in care

Substance misuse services

Staff involved clients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that clients had easy access to additional support available.

The treatment plan was discussed as part of the assessment process, and the client's consent was discussed and documented. Risk and recovery care plans were developed as part of the assessment in consultation with the client. Clients were provided with copies of their recovery plans. This included on discharge, as the recovery plan was seen as part of an ongoing process.

Staff signposted clients to additional support outside the service. This included organisations where they could get legal advice and support with benefits.

The service had a client representative, who was a detox practitioner and former volunteer. The regional manager was the client engagement lead for the service.

All clients were given a feedback form on discharge. We saw five feedback forms which were very positive. Common feedback was that staff went "above and beyond" in providing support.

The service had a "what you asked for and what we did" board. This showed that clients had raised issues, and the service had responded. The issues raised were primarily requests for additional items in the service, but there were also changes to restrictions. Many of the requests had been responded to – for example a pool table had been purchased, as had clocks, a new stereo and toaster, and a clients' fridge. A vending machine had also been installed following requests from clients. Changes had been made to restrictions and to other practices within the service in response to feedback from clients. This included the provision of caffeinated tea and coffee, clients now waited for medicines in the reception area rather than standing outside the medicines room, and naloxone training was provided to clients and families on request.

Staff informed and involved families and carers appropriately.

There were no specific groups for families and carers. Informal support was provided, and this may be by phone if families did not live near the service. Visiting was usually limited to weekends, but the times for this had been extended following discussion with clients.

The service was not funded/contracted to provide naloxone training, but this was offered to family members if it was thought it might be of benefit.

Are substance misuse services responsive to people's needs?

(for example, to feedback?)

Good 

Access, waiting times and discharge

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

Clients were referred to the service through several routes. There were specific contracts with local authorities, spot purchases from individual health care organisations and local authorities, and individuals purchasing their own treatment. Clients were primarily admitted for medical detoxification from alcohol or drugs. There was a recovery programme as part of this, but many clients were transferred to other services in their home area for further rehabilitation and recovery.

The average length of stay varied depending on the specific detoxification programme. The alcohol detoxification programme usually lasted from three to seven days. Drug detoxification programmes usually lasted at least 28 days. If clients had an alcohol related brain injury, the programme was tailored to their needs. The longest admission was three months. At the time of inspection, the rate of successful completion of treatment was 98%.

Referral to assessments targets were met. Assessments were carried out within a day to a week of referral, depending on when information was received from the client's GP. Urgent assessments were carried out quickly when required, for example if someone needed urgent admission from an emergency department. The performance information for Shropshire in January to March 2019 showed that all clients had been assessed within the target of three weeks from referral. This also

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showed examples of positive working to take clients in an emergency. The service had no waiting list. Several of the commissioners had preferred admission days, which the service facilitated.

There were several examples of staff at the service going beyond their funded/contractual arrangements to provide support for clients. This demonstrated a commitment to supporting and promoting clients' recovery and welfare based on their individual needs. This included extended support when clients were discharged, supporting clients who had not been admitted because they were too unwell, and carrying out actions to facilitate client's discharge and recovery.

Facilities that promote recovery, comfort, dignity and privacy

The design, layout, and furnishings of the ward supported clients' treatment, privacy and dignity. Each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.

The food was of good quality and clients could make hot drinks and snacks at any time. Clients were positive about the food in the service. Drinks and snacks were available at all times. Staff were aware of individual clients dietary preferences and needs, and appropriate food was available. There was a vending machine, at the request of clients, that was reasonably priced and listed nutritional information about the food available. Clients had a fridge to store their own food.

Clients' engagement with the wider community

Staff supported clients with activities outside the service, such as work, education and family relationships.

Clients were supported to maintain relationships with their families where possible. Friends and family were able to visit clients at weekends.

Many of the clients were undergoing alcohol detoxification programmes which were relatively short, usually less than a week, so there was limited opportunity to engage with local services. Services were commissioned from outside the local area, such as Shropshire and London, so clients were not able to readily access local services in the area they were returning to. Clients from Shropshire were

provided with written information about their local services. Staff from Wirral community service visited the service weekly to talk with clients about what they could access once they'd finished their detoxification programme.

Meeting the needs of all people who use the service

The service met the needs of all clients – including those with a protected characteristic. Staff helped clients with communication, and cultural and spiritual support.

The service had three bedrooms on the ground floor, that had ensuite facilities and were accessible by people in wheelchair. There was a lift between the main ground and lower ground floors so that all the communal areas were accessible.

The service had an LGBT+ lead. There was a gender neutral toilet within the service.

Clients had access to a prayer room. Staff from the local diocese were due to provide pastoral care in the service.

Food was prepared onsite, and could cater for clients with health, religious or cultural dietary needs or preferences.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service had a complaints policy, that staff were familiar with. Staff told us that they did not receive many complaints, and that they were usually of a relatively minor nature, that they attempted to resolve directly with the client.

Clients and their relatives were provided with information about how to make a complaint. This was included as part of the welcome pack, and information about complaints and compliments was on display. Clients could raise concerns with staff directly, or in the daily community meetings. The complaints and compliments leaflet provided information about how to make a complaint, how quickly a response would be received, and how to escalate it to the board and chief executive if they were not satisfied with the response.

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We reviewed a sample of complaints and found that these had been responded to appropriately in accordance with the service's policies.

Are substance misuse services well-led?

Good 

Leadership

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

Managers received leadership training from the Kaleidoscope Project. Managers told us they felt supported within the service, had the authority to make decisions, and could access advice and support. Managers had relevant experience and were knowledgeable about the area they worked in. The registered manager carried out a 360 degree feedback process in 2018, and information from this was shared through supervision. Staff within the team received coaching from a member of the Kaleidoscope Project's executive team.

Staff were positive about local and more senior managers. They told us they were visible, and that they found them supportive. They knew who to approach for advice and support.

Vision and strategy

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

The organisations values were integrity, innovation, engagement and excellence, and they were displayed in the service. Staff were familiar with the organisation's values, and told us they believed this to be part of their work. Staff told us that the chief executive had explained the service's vision and proposed five year plan and asked for input on this. The standard staff supervision template included a review of how the staff member had demonstrated the organisation's values since the last supervision session.

Culture

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

Feedback directly from staff and through comment cards was overwhelmingly positive. Staff told us they enjoyed working in the service, and felt supported by their colleagues and managers. They expressed a positive attitude towards clients, and felt they could raise concerns and suggestions. Staff told us they had been supported with their own physical and emotional health needs.

Team meetings took place. Staff told us that they were typically once a month, but may be less frequent. There was a standard agenda, and minutes showed that information was shared with staff, and that staff were able to raise concerns and make suggestions.

Staff were provided with free food, and there was temporary accommodation for staff who came to the service from the Kaleidoscope Project's other services in Wales.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The provider had a corporate governance structure, which Birchwood Residential Treatment Centre was part of. The service had a monthly clinical governance meeting. This was attended by local and regional managers and the clinical director. There was a standing agenda, which fed into the corporate governance structure. The agenda included monitoring and reviewing of actions such as staffing, client issues, incidents, health and safety issues, performance, developments, and finances. In addition to performance data, qualitative issues were also discussed. This included reflections on specific incidents, or identification of themes within the service. Clinical audits were routinely carried out, and a rolling audit plan had been developed.

The service provided commissioning reports for its key commissioner, which included key performance indicators. A sample report covering January to March 2019 showed that extensive information was provided. This included

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details about individual clients and about the service generally, including incidents, audits, risk register, and developments. The sample report showed that there had been no significant issues, that staffing was at 100% of requirement, and that all clients had been admitted within the three weeks of referral target, and that all clients from that commissioner had completed feedback forms on discharge. Other commissioners requested and received a basic information summary. These did not show any significant issues or concerns.

Notifications were submitted to external organisations as required, which included the Care Quality Commission.

The service had a whistleblowing policy. Staff told us they felt able to speak out if they had any concerns.

Management of risk, issues and performance

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

Managers had access to the local and elements of the corporate risk register. They escalated concerns when required, and these were reviewed and removed when necessary. The service had plans for the action to take in the event of an emergency. Changes were made as a result of this. For example, there had been problems with the heating during the last winter that were out of the control of the service. They had taken action to address the immediate problem, and had a plan to reduce the risk of this happening again.

Information management

Staff collected and analysed data about outcomes and performance.

Staff had secure access to the service's electronic care record and incident management systems. An additional

office had been allocated so that staff could access the systems. Information about the service was stored on a shared drive. Managers could access information on the system remotely, to support them in their role.

Treatment outcomes profile forms were completed for each client and submitted to Public Health England.

Engagement

Managers engaged actively other local health and social care providers to ensure that people with substance misuse problems experienced seamless care.

All clients were given a feedback form on discharge from the service. Clients could also access an ongoing online survey. This information was discussed in the governance meetings. Information about feedback was shared with commissioners.

Clients told us they knew how to raise concerns, and that local and regional managers were visible.

The service was part of the local frequent attenders meeting, with representatives from health and social services, the police and Healthwatch.

Learning, continuous improvement and innovation

The service had developed an innovation fund for staff and clients to put forward suggestions for ideas that would benefit the service.

Staff had received training for detoxification from phenibut (an anti-anxiety drug that is also used recreationally) following an identified need.

The service was promoting an initiative against period poverty. They supplied free sanitary products to clients and staff.

Outstanding practice and areas for improvement

Outstanding practice

There were several examples of staff at the service going beyond their funded/contractual arrangements to provide support for clients. This demonstrated a commitment to supporting and promoting clients' recovery and welfare based on their individual needs. This included extended support when clients were discharged, supporting clients who had not been admitted because they were too unwell, and carrying out actions to facilitate client's discharge and recovery.

The service was an active part of the frequent attenders group, that aimed to improve outcomes for clients who frequently presented at the local emergency department.

The service was promoting an initiative against period poverty. They supplied free sanitary products to clients and staff.

Areas for improvement

Action the provider SHOULD take to improve

The provider should ensure that all areas of the building are adequately clean and maintained. Most areas of the building were clean and tidy, but the shower sealant and grouting was stained, and there were residual damp stains on some of the ceilings.