Cherry Tree Cottage

Quality Report

Cherry Tree Cottage
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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 Cherry Tree Cottage as good because:

- The service provided safe care. The environment was safe and clean. There were enough support staff, and medical staff to provide safe care and treatment. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment in conjunction with clients. They provided a range of therapy and therapeutic activity suitable to the needs of the clients in line with national best practice guidance. Staff engaged in clinical audit to evaluate the quality of care they provided.

Summary of findings

- Staff treated clients with compassion and kindness, respected their privacy and dignity and understood the individual needs of clients. They actively involved clients in care decisions and involved family members where appropriate.
- Staff planned and managed discharge well, offered aftercare through their own service and liaised well with other services that would provide aftercare. The service had clear procedures in place for people who requested to leave the service unexpectedly.
- The service worked to a recognised model of rehabilitation. It was well led and the governance processes ensured that the service ran smoothly. Following the CQC inspection in 2017, the service promptly undertook all areas of improvement we told them they must and should make.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Good	

Summary of findings

Contents

Good

Cherry Tree Cottage

Services we looked at
Substance misuse services

Summary of this inspection

Background to Cherry Tree Cottage

Cherry Tree Cottage location was registered with the CQC in October 2016 to provide:

• Accommodation for persons who require treatment for substance misuse

• Treatment of disease, disorder or injury

• Care for adults under 65 years.

The service provides supported accommodation for up to nine clients seeking support with recovery from drug and alcohol addictions.

Cherry Tree Cottage provides its service in a three-storey semi-detached Victorian house on a residential street in Birmingham. Cherry Tree Cottage provides a nine bedded residential drug and alcohol detoxification and rehabilitation programme for men and women aged over 18 years. The location has clients participate in a 12-step recovery programme tailored to their needs. Clients access the service through professional referral or self-referral. Most clients are self-funding. The service also provides after care to discharged clients in the form of day care.

Cherry Tree Cottage has a nominated individual and registered manager in place, who is also a director of New Leaf Recovery Community Interest Company.

Our inspection team

The team that inspected the service comprised of two CQC inspectors.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health 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:

- visited Cherry Tree Cottage, looked at the quality of the environment and observed how staff were caring for clients
- spoke with four clients who were using the service
- spoke with the registered manager, administration manager and service manager
- spoke with seven other staff members; including the prescribing doctor
- looked at four care and treatment records of clients
- carried out a specific check of the medication management
- 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

We spoke with all four clients. They told us that the staff were respectful and treated them well. They told us the experience and genuine nature of staff helped them with their recovery. They told us the service contributed to them getting their life back and the service felt like a family.

Staff understood the individual needs of clients, including their personal, cultural, social and religious needs.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The service was safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough skilled staff who knew the clients and received basic training to keep people safe from avoidable harm.
- Staff assessed and managed risks well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate client recovery.
- Staff understood how to protect clients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation 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.
- Staff followed best practice when storing, dispensing and recording the use of medicines. Staff regularly reviewed the effects of medications on each clients physical health.
- The service had a good track record on safety. The service managed client safety incidents well.

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all clients on admission. They developed individual care plans which were reviewed regularly and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the client group. This included access to therapies in line with national guidance on best practice and support for self-care and the development of daily living skills. Staff 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 and quality improvement initiatives.

Summary of this inspection

- Staff supported clients to make decisions about their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for clients who might have impaired mental capacity.

Are services caring?

Good

We rated caring as good because:

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

Are services responsive?

Good

We rated responsive as good because:

- The service had a clear referral criteria and signposted clients on to more appropriate services if needed.
- Staff planned and managed discharge well. All clients had an unexpected exit plan.
- The service took account of clients individual needs. The service met the needs of all people who use the service – including those with a protected characteristic. Staff helped clients with communication, advocacy and cultural and spiritual support.
- 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.
- The design, layout and furnishings of the service supported clients' treatment, privacy and dignity. There were quiet areas for privacy and a well maintained outside space.

Are services well-led?

Good

We rated well led as good because:

- Managers had a good understanding of the service they managed. They had the skills, knowledge and experience to perform their roles, were visible in the service and approachable for clients and staff.
- Staff felt respected, supported and valued. They reported that the provider promoted opportunities for development. They felt able to raise concerns without fear of retribution.

Summary of this inspection

- Our findings from the other key questions demonstrated that governance processes operated effectively and that performance and risk were managed well.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

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

Cherry Tree Cottage was not registered to provide treatment under the Mental Health Act and therefore did not accept clients that were detained.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff completed Mental Capacity Act and Deprivation of Liberty Safeguards training. Staff we spoke with understood impaired capacity in relation to intoxication and detoxification. Staff gained consent to treatment from clients on two occasions within the first seven days of treatment. We saw consent forms signed at these intervals within client records.

Notes

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

Safety of the facility layout

Staff undertook regular assessments of the environment to ensure it was safe and clean.

The premises were laid out across three floors and there were multiple blind spots and ligature risks. This is normal within this type of service. Staff completed yearly ligature risk assessments and were aware of the risks. Staff reduced these risks by individual client risk assessment and management plans, observations and CCTV. The service did not admit clients assessed as a high suicide risk. We found that the ligature risk assessment was up to date and thorough.

The provider had up to date fire assessment in place. Fire safety precautions such as smoke alarms and fire-fighting equipment were present. Staff had placed fire evacuation plans in the main hallway and on the backs of doors. Staff told us they pointed these out to clients on admission. On inspection, staff informed us of fire safety procedures. All staff had completed fire safety training. The provider ensured that a daily fire marshal was allocated to each shift.

We reviewed logs that confirmed that staff recorded when checks of equipment and alarms were undertaken.

The provider could provide a women only space if needed and were able to manage bathroom and toilet facility access to ensure safety, privacy and dignity adequately. The facility had several ensuite bedrooms to enable this.

Since our last inspection in 2017, the provider had introduced staff call alarms in all bedrooms. This meant clients could summon staff in an emergency if needed. Staff also carried mobile alarms to summon assistance if needed.

Night staff had access to an out of hours emergency call centre for support if needed.

Clients and staff we spoke with reported they felt safe at Cherry Tree Cottage.

Maintenance, cleanliness and infection control

All areas of the premises were visibly clean, tidy and well maintained.

Staff adhered to infection control principles, including handwashing and the disposal of clinical waste. The provider had a policy in place to guide staff. Clients completed cleaning duties on a rota system as part of therapeutic activity. Staff oversaw and supported cleaning of the environment and ensured this was completed to a good standard.

The provider had a five star rating from the food standards agency.

The service had a legionella risk assessment in place and had implemented all the recommendations given.

Clinic room and equipment

Since our last inspection in 2017, the provider had completed a building extension. This included a new clinic

room. The clinic room was visibly clean and tidy. Equipment for the monitoring of physical health was present and included scales, blood pressure monitoring equipment, thermometers, scales and breathalyser. They were in working order and dates for future calibration documented.

Safe staffing

The staff team consisted of the registered manager, service and administration managers, substance misuse workers, maintenance worker, housekeeper and chef. The staff team worked alongside two prescribing doctors who provided medical input to the service. This included medical detoxification and any physical health assessments. The doctors provided cover for each other whilst on leave and both had additional training and special interests in the treatment of substance misuse. In addition, the service contracted counsellors as needed and also had support from volunteers.

There were enough staff on each shift to safely manage the service. Managers had calculated the number of staff required and could adjust levels if clients required more support. The service did not use bank or agency staff.

Staffing levels allowed clients to have regular one-to-one time with their named support worker. There was no evidence of short staffing or cancellations of the therapy programme due to staffing.

The service had contingency plans to manage unforeseen staff shortages including, arrangements for sickness, leave and vacant posts.

In the twelve months prior to inspection six paid staff had left the service. The manager told us that most staff had left due to natural career progression or for personal reasons.

In the twelve months prior to inspection staff sickness stood at 2.7 % which is below the national average.

All staff we spoke with said that current staffing levels were sufficient, however, a few months earlier had felt increased pressure to undertake work due to staff leavers. Rotas we reviewed showed that adequate numbers of staff were available throughout the shift system.

Medical staff

The staff team worked alongside two prescribing doctors who provided medical input to the service. This included medical detoxification and any physical health assessments. The doctors provided cover for each other whilst on leave and both had additional training and special interests in the treatment of substance misuse.

Staff used emergency services in the event of a medical emergency.

Mandatory training

The service has a programme of mandatory training and manager's ensured staff were up to date. Courses included: emergency first aid, health and safety awareness, fire safety awareness, food hygiene and safety, infection control, Mental Capacity Act 2005, risk assessment, safeguarding, safe handling and storage of medication level 2, Naloxone overdose intervention, safeguarding, conflict management, methadone awareness, care planning, detoxification management and observations.

The training offered embedded personal safety protocols for staff including lone working policies.

Assessing and managing risk to client and staff

Assessment of client risk

Staff completed a risk assessment of every client on admission and updated it regularly, including upon completion of detoxification and after any incident.

On inspection we reviewed four client care and treatment records. We found each had a risk assessment and management plan in place. They were personalised and linked with care plans. One risk assessment and management plan showed in depth discussion and joint management of risks with external agencies. Another clearly spelt out risks following a recent dental procedure. All records had additional pre- populated risk templates outlining specific withdrawal risks. Staff used these as prompts in addition to the generic risk assessment. Records showed that staff updated risk assessments as appropriate and they were signed by both staff and clients.

Risk assessments were comprehensive, and documented indicators of deterioration in health, risk to others and children, including any contact with children that might not have been directly related.

Management of client risk

Staff told us they adhered to the service admission criteria in order to reduce risks to clients. Staff told us that the

service did not accept people with severe mental illness, high suicide risk, physical illnesses or poor mobility. Staff told us they only accepted clients with moderate drug and alcohol dependency who they had assessed as suitable for a community detoxification.

Staff made clients aware of the risks of continued substance misuse and harm minimisation and safety planning was an integral part of recovery plans. Staff revisited advice at intervals throughout treatment and as part of therapeutic activity. We saw staff had documented this

in care records when harm minimisation advice had been given to clients who had wanted to discharge before completing the programme.

We saw documented evidence within care records that staff identified and responded to changing risks to, or posed by, clients.

Staff responded promptly to sudden deterioration in people's health. Staff shared examples of when this had happened and how they had managed the situation.

Staff adhered to best practice in implementing a smoke-free policy. Clients were not allowed to smoke within the premises. Staff supported clients with nicotine replacement when requested.

Risk assessments included early exit plans. This meant for clients who did not choose to complete the detoxification programme, staff and client had agreed a plan of support for follow up.

Staff applied blanket restrictions only when justified. There was a list of restrictions in place while clients were in treatment to promote safety and recovery and these were provided to the client before agreeing to admission. These were known as house rules. Clients signed to say they agreed to the rules and restrictions in place on admission. The house rules included restrictions on when clients could leave the premises and access to mobile and internet. These

are normal rules within a residential substance misuse service. Staff documented clearly in client records that clients understood what they were agreeing to on admission. None of the clients we spoke with expressed any concern about the restrictions.

Staff followed policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching clients or their bedrooms.

Staff used observations based on risk and stage of treatment, for example, during detoxification observation levels were higher. The facility had a downstairs detoxification suite located near the staff office, which consisted of a double bedroom for clients in the early stages of detoxification. Staff recorded all observations in care records.

There was a comprehensive search policy in place and consent was taken to conduct searches. If a search was carried out, clients signed to consent and show they understood why these were conducted. Consent forms were stored in care records.

Use of restrictive interventions

Staff did not use seclusion or long term segregation.

Staff did not use rapid tranquilisation.

Staff did not use restraint. Staff had completed training in non-violent crisis intervention and conflict management to manage potential challenging behaviours.

Safeguarding

Staff could give examples of how to protect clients from harassment and discrimination, including those with protected characteristics under the Equality Act.

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 knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies to safeguard people at risk. Staff could give examples of how to protect clients from abuse and recorded this in care records.

Staff access to essential information

Staff used paper care records. All information needed to deliver client care was available to all relevant staff when they needed it and it was in an accessible form.

Medicines management

Good

Substance misuse services

Staff had effective policies, procedures & training related to medication and medicines management including: prescribing, detoxification, assessing people's tolerance to medication, and take-home medication e.g. naloxone.

Staff followed good practice in medicines management (that is transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance. Staff dispensed medication in pairs and countersigned medication cards. Staff recorded clinic room and medicines fridge temperatures daily to ensure medicines were kept within temperature range, in order to maintain medicine efficacy.

The prescribing doctor issued a private prescription to those clients needing a medical detoxification. The detoxification was medically monitored. This means that enough medical supervision was provided by a visiting GP, who has had additional substance misuse training.

Staff reviewed the effects of medication on clients physical health regularly and in line with National Institute for Health and Care Excellence guidance. Staff recorded reviews within client care records.

We reviewed four client medication files. Staff attached a photograph of the client to the medication administration record sheet. We saw that staff had documented name, date of birth, allergies, GP and consent in the front section of the file. Staff had completed all the medication administration record sheets correctly. Staff gave clients their medication in a private area next to the clinic room and they signed the medication administration record sheet to indicate they had taken the medication.

Staff completed monthly medication audits. We reviewed audits for the last three months. We could see that no major concerns had been identified as a result of the audits.

Staff had access to naloxone. Naloxone is a medication that reverses the effects of an overdose from opioids (e.g. heroin, methadone, morphine). The staff had access to a service naloxone policy for guidance.

Staff completed the Clinical Institute Withdrawal assessment of alcohol every time they administered diazepam. We could see from reviewing medicine charts that the doctor tailored diazepam detoxifications to meet individual needs.

Track record on safety

There have been no serious incidents reported within this service in the 12 months before inspection.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report. We reviewed the incident recording log and could see that since the last inspection, the provider had made improvements to the incident report form. Incidents were reported in detail and it was clear what actions had been taken and by whom. Staff had reported a range of incidents and had an incident policy to follow for guidance.

Staff understood the duty of candour. Following the inspection in 2017 we told the provider that they should have a duty of candour policy in place. On this inspection we found that the provider had written a duty of candour policy and ensured that staff had read and understood the policy.

We saw and staff told us about, improvements in safety following incidents for example, improvements and changes to the environment.

Staff met to discuss that feedback about incidents and learning through team meetings. Minutes of these meetings confirmed staff undertook discussion and action following incidents.

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

Good

Assessment of needs and planning of care

On inspection we examined four client care records. We found staff completed a comprehensive assessment in a timely manner. Staff developed care plans that met the needs identified during assessment. The recovery plan identified the person's key worker. Staff and clients reviewed individual needs and recovery plans, including risk management plans regularly. Staff updated care plans when necessary. Staff developed a risk management plan for those people identified as being at risk that included a plan for unexpected exit from treatment. Care plans were holistic, personalised and recovery orientated. Care plans

were clearly developed in conjunction with the clients and often used the clients own words. The care plans were specific, measurable, achievable, relevant/ realistic and time specific. This was in line with guidance from The National Institute for Health and Care Excellence (QS14).

The doctors completed a full assessment on the same day of admission. This included a physical health examination. This included physical observations such as blood pressure, pulse and a drugs screen. Staff breathalysed clients to confirm alcohol levels. Staff recorded the results in a separate file to the care plans. The doctor completed a full assessment of substance

misuse including mental state and risks.

The prescribing doctor conducted a medical assessment of all clients, including those who did not need medical detoxification.

Best practice in treatment and care

Staff provided a range of treatment and care for clients based on national guidance and best practice. The therapy timetable incorporated structured psycho-social interventions including 12-step addiction programmes, access to anonymous addictions groups and therapeutic activities to support clients with recovery. The service also had access to a local gym twice a week. Staff supported clients to access a local gym twice week to participate in swimming or other gym activities.

The service offered detoxification where appropriate and subject to assessment of need. The

service offered testing and referral for treatment for blood borne viruses where appropriate.

The service offered auricular acupuncture. Auricular acupuncture is ear acupuncture to aid the detoxification process and wellbeing.

Staff supported clients to live healthier lives for example, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse.

Staff used technology to support clients effectively for example the loan of portable personal music players to listen to mindfulness or meditation.

Staff used recognised rating scales to assess and record severity and outcomes. For example, staff used standardised assessment tools. For example, the severity of alcohol dependence questionnaire (SADQ) and clinical institute withdrawal of alcohol (CIWA) scale. This enabled the service to document the ongoing condition of clients during treatment more clearly.

Staff participated in various audits, for example, medication and case note audits. Staff had clearly documented outcomes from these audits.

Skilled staff to deliver care

Staff who worked at the service had a range of skills needed to provide care and support. The prescribing doctor had additional substance misuse training from the Royal College of Psychiatrists.

Three members of staff had completed the health and social care NVQ level three and a further three were in the process of completing this level. The registered manager had successfully completed level 5 and the administration manager was working towards this. One member of staff had a diploma in addictions counselling and another member of staff had completed a degree in drug and alcohol counselling.

Many of the staff working with people in recovery had been on recovery programmes themselves. This enabled them to be empathic with people using the service. The service recruited a number of volunteers to work alongside the recovery and support workers. The volunteers received induction, support and training for the roles they undertook.

In addition, the service offered a psychology student placement to a local university and had also offered a student counsellor placement.

All clinical staff had an allocated supervisor for one to one supervision. We reviewed records that documented supervision discussions between staff. All staff received yearly appraisals.

The service provided all staff with a comprehensive induction and kept a record of completion in individual staff files.

All staff received regular supervision and a yearly appraisal from appropriate professionals. Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. This

Good

Substance misuse services

was evident within supervision and appraisal notes. Staff confirmed that the provider supported staff to access training. In service training was provided on a regular basis as well as access to external training.

The service ensured that robust recruitment processes are followed. We reviewed four staff files. We found them to be in good order. They all included photo identification, job application, job description, contract of employment, signed code of conduct, training certificates, DBS checks and supervision logs.

Managers told us that poor staff performance would be addressed promptly and effectively.

Multi-disciplinary and inter-agency team work

Where appropriate the service worked alongside side other professionals, for example probation, community mental health teams and other health care professionals. We saw examples of recovery plans including clear care pathways to other supporting services.

Each client had an allocated care coordinator.

Staff held regular meetings to discuss progress and interventions. The team held regular business and support meetings. Staff took part in handovers between shifts to share information and hand over tasks to be completed.

Good practice in applying the Mental Capacity Act

Staff had access to a Mental Capacity Act policy.

All staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training (DoLS).

Staff we spoke with understood impaired capacity in relation to intoxication and detoxification. Staff gained consent to treatment from clients on two occasions within the first seven days of treatment. We saw consent forms signed at these intervals within client records.

Care records we looked at showed that clients had signed consent to treatment, sharing of information and confidentiality agreements. This concurred with our observations and with statements by staff and users of the service, who emphasised how they were aware of

and agreed with, their treatment.

Are substance misuse services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated clients with respect and compassion. They respected clients' privacy and dignity, and supported their individual needs. We observed staff interacting in a professional and open manner with clients and demonstrating individual knowledge through meaningful interactions.

Staff supported clients to understand and manage their care, treatment or condition. This included one to one and group discussions.

Staff directed clients to other services when appropriate and, if required, supported them to access those services. This included physical health care facilities, for example dentists or services near the clients' home.

We spoke with all four clients, they told us that the staff were respectful and treated them well. They told us the experience and genuine nature of staff helped them with their recovery. They told us the service contributed to them getting their life back and the service felt like a family.

Staff understood the individual needs of clients, including their personal, cultural, social and religious needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to facilities clients without fear of the consequences

The service had clear confidentiality policies in place that were understood and adhered to by staff. Staff maintained the confidentiality of information about clients. Care records were stored in locked cabinets. Clients we spoke with told us they understood the service confidentiality policy and staff had explained it to them on admission with signed consent forms and confidentiality agreements. We saw these completed in care records.

Involvement in care

Involvement of clients

Staff used the admission process to inform and orient clients to the service.

Good

Substance misuse services

Each client using the service had a recovery plan and risk management plan in place that demonstrated the persons' preferences, recovery and goals.

Staff communicated with clients so that they understood their care and treatment, including finding effective ways to communicate with clients with communication difficulties. Staff gave an example of a client who was unable to read and write. Staff worked with the client using a voice recording system to complete the work, staff transcribed this into files, they identified the clients learning style (i.e. audio-visual learning) and delivered the therapy programme using video and music learning techniques.

Staff engaged with clients using the service, their families and carers to develop responses that met their needs and ensures they have information needed to make informed decisions about their care.

Staff actively engaged clients using the service (and their families/carers if appropriate) in planning their care and treatment. Clients told us how staff had provided support to families and friends. The service offered family and carer liaison support to clients that consented. This included mediation and one to one advice and support about addiction and recovery.

Clients were encouraged to give feedback about the service through various methods. For example, community meetings, suggestion box and feedback forms. Clients could attend a weekly community group. This was for staff and clients to discuss the processes of residential treatment, voice concerns and suggestions. Clients discussed and agreed the weekly menus at this meeting and allocated who did household chores. The community group minutes we reviewed confirmed this to be the case.

Staff were able to share how they had developed the service after feedback from clients. One example was in response to feedback from after-care clients. After reviewing the feedback, the staff team reviewed and tailored the therapy package more finely to meet the needs of the specific aftercare group.

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

Good

Access, waiting times and discharge

The service was available to people nationwide. They took self-referrals and referrals from other organisations. The service had clear referral criteria. The referral criteria excluded any clients they deemed high risk, for example anyone actively suicidal, with complex mental illness, a history of sexual offences or a history of violence.

A referrals coordinator screened all referrals by telephone prior to assessment. Staff sign posted clients elsewhere if they did not meet the Cherry Tree Cottage referrals criteria. The manager gave examples of referrals that had been declined as they did not meet the criteria and presented risks the service could not manage safely, for example, severe physical or mental health needs.

The service offered next day assessments after the initial referral screen if there were vacancies. The service was also able to offer home assessments in some circumstances prior to admission.

Clients used the service for pre agreed treatment periods. This rarely exceeded twelve weeks. Some treatment periods were as short as two weeks.

At the time of inspection, there were no waiting lists.

Staff said they discussed discharge plans with clients as part of the treatment process. We could see evidence of this in records and clients spoke of one to one sessions to plan discharge.

The service offered on going day care for clients discharged from residential care.

The service offered support after discharge, with provision for secondary care at another location.

The service had links with supported accommodation projects in the local area.

The facilities promote recovery, comfort, dignity and privacy

The service had a mixture of single and double bedrooms. Double bedrooms were single sex and used in the early

stages of detoxification, where clients were paired up to provide extra support. Clients had access to ample bathrooms on their own corridor or en suite. The service had quiet areas which could be gender specific if needed.

Clients could personalise bedrooms if they wanted and had access to secure storage.

Staff and clients had access to a full range of rooms and equipment to support treatment and care. The service had completed a building extension in 2018 which had provided extra room at the facility. The service had also built a lodge room in the garden which had been named 'Serenity' lodge. It was available to clients as an additional quiet area.

The service restricted client's access to mobile phones and internet. This was to avoid interference with the group programme. All clients agreed to this restrictive practice on admission as part of the treatment approach.

Clients had access to a garden area. It was well maintained and provided a sheltered seating area. The garden had been designed by a client in recovery.

Clients told us that the food was of an adequate standard. They had access to snacks and hot drinks throughout the day and night.

Clients' engagement with the wider community

Staff supported clients to access education and work opportunities if and as identified within individual recovery programmes.

Staff supported clients to maintain contact with their families and loved ones if they wanted to. Staff encouraged clients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

The therapy timetable incorporated visits to community venues and groups and shopping activities. Clients had access to a local gym twice a week.

Meeting the needs of all people who use the service

Staff demonstrated an understanding of the potential issues facing vulnerable groups e.g. lesbian, gay, bisexual and transgender, black minority ethnic groups, older people, people experiencing domestic abuse and sex workers and offered appropriate support.

Staff made adjustments for disabled people for example ensuring access to premises and by meeting the clients' specific communication needs.

The service provided information about local and national treatment services, advocacy and how to complain.

Clients had a choice of meals and the service catered for varied diet choices, allergies or religious preferences.

Listening to and learning from concerns and complaints

Staff protected clients who raised concerns or complaints from discrimination and harassment.

The service had a clear complaints system to show how complaints are managed and lessons are learnt and acted upon to improve the quality of the service. Complaints records demonstrated that individual complaints have been responded to in accordance with the service's complaint policy

The service had one formal complaint in the 12 months prior to inspection and 25 compliments. The registered manager shared with us learning from the complaint and actions the service had taken to improve.

Clients we spoke with told us they knew how to make a complaint and felt they would if needed.

Are substance misuse services well-led?

Good

Leadership

The service had a registered manager, administration manager and service manager. They had the right skills and experience to perform their role.

The leaders showed good understanding of the service, staff and client group. They could explain clearly how the staff were working to provide good care. They were visible and approachable in the service for clients and staff.

The provider supported staff in undertaking and developing leadership skills. For example, funding and supporting additional training.

Vision and strategy

Good

Substance misuse services

The service had a vision for what it wanted to achieve and staff had the opportunity to contribute to discussions about the strategy for their service.

Staff we spoke with knew and understood the visions and values of the service. They all wanted to make a difference and support people through their recovery. They understood the need for personalised care and support. Many of the staff had undergone their own recovery and gained the skills to support others through addiction.

Culture

The manager promoted a positive culture that supported and valued staff. Staff we spoke with felt respected, supported and valued. Staff felt positive and proud about their job and working for the service. Staff were actively encouraged and supported by management to develop and achieve in their roles. Staff received support for their own physical and emotional health needs from management. The service had a relapse policy in place for those staff who were in recovery.

Staff worked well together and where there were difficulties managers dealt with them appropriately. Staff told us they could raise a concern without fear of the consequences.

Appraisals included conversations about career development and how the service could support staff.

Governance

The service monitored the quality of the care and support provided and ensured there were effective governance arrangements in place. The manager had a system in place to review the effectiveness of policies and procedures and update them as needed. There was a clear framework of what needed to be discussed in team meetings and fed back to the board to ensure that essential information, such as learning from incidents, safeguarding and complaints, was shared and discussed.

Staff undertook local clinical audits and acted on the results. Data and notifications were submitted to external bodies and internal departments as required.

The service had a whistle blowing policy in place. Following the CQC inspection in 2017 we told the provider that they must ensure they have a duty of candour policy. The service had since developed a policy and ensured all staff had undertaken training to support the policy.

Management of risk, issues and performance

The manager monitored staff sickness, turnover and performance effectively. The service had plans for emergencies, for example, adverse weather or a flu outbreak. No staff were subject to performance management at the time of inspection.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of client records.

Service managers had access to information to support them with their management role. This included information on the performance of the service, staffing and client care. Information was in an accessible format and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. For example, the CQC and public health England.

Engagement

Clients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. They could meet with the manager to give feedback if they wanted to and the managers were available and approachable to do so.

The service had a comprehensive and up to date website sharing information about the service, addictions and recovery.

The service collected client feedback on a regular basis. Documents we reviewed showed that staff reflected and acted upon feedback from clients.

Learning, continuous improvement and innovation

The service encouraged creativity and innovation to ensure up to date evidence based practice is implemented and imbedded. For example, they reviewed the quality of the premises and extended to provide a more comfortable environment for clients and staff. This included creating a larger clinic room and staff office as well as a ground floor detoxification suite.

All staff had objectives focused on improvement and learning.

Good

Substance misuse services

The directors were able to share development plans for the next twelve months and had set goals to continuously improve the service and support development of staff and volunteers.