PCP (Clapham) Limited

PCP Clapham

Quality Report

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This report describes our judgement of the quality of care at this service. 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.

Summary of findings

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Summary of findings

Overall summary

PCP Clapham is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury

There is a registered manager in place.

PCP Clapham provides a day therapy service for people with substance misuse problems, including rehabilitation and alcohol and opiate detoxification where needed.

During the inspection we identified serious concerns about the care and treatment of patients going through alcohol and opiate detoxification. There were no detailed protocols in place to support staff caring for patients going through detoxification from alcohol or opiates. There were no written admission criteria identifying who could be safely admitted to the service and which patients needed to go through assisted withdrawal in a hospital setting. Most staff, other than the recently appointed nurse, had not been trained in the complications of withdrawal from alcohol and/or opiates and had only a superficial knowledge of the signs and symptoms they needed to look for. There had been three incidents of patients suffering seizures during withdrawal between January 2014 and May 2015.

As a result of the serious concerns identified we served the provider a Section 31 of the Health and Social Care Act 2008 notice, on 3 August 2015, to impose conditions in relation to their registration to provide the regulated activity of treatment of disease, disorder or injury. PCP (Clapham) Limited is not to admit patients who require assisted withdrawal from alcohol or opiates to PCP Clapham, Unit 2, 376 - 378 Clapham Road, London SW9 9AR, until adequate arrangements and systems are in place to provide safe care and treatment to patients requiring alcohol or opiate detoxification.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service did not have detailed written protocols in place in respect of assisted alcohol or opiate withdrawal to enable staff to provide safe and appropriate care and treatment to a patient withdrawing from alcohol or from opiates. Staff did not carry out regular physical health checks on patients undergoing alcohol detoxification in order to identify withdrawal symptoms and any physical health concerns. Most staff did not have sufficient training to be able to provide safe care to patients undergoing assisted alcohol withdrawal or opiate detoxification. Patient risk assessments did not always identify risks associated with patients' mental health. The provider had not conducted proper checks on staff before they were employed to ensure that suitable people were working in the service and patients were not put at risk. The training requirements for different staff roles in the service had not been assessed. Mandatory training was limited to two areas and did not cover all basic responsibilities staff undertook. There were no set timescales for refreshing or updating training to ensure it remained current. There were no proper systems in place to monitor the safety of the environment. The service had not had a fire risk assessment since 2012. Fire drills had not been carried out at the premises. The service had not conducted an infection control risk assessment or audit in the last 12 months. Staff had not always acted promptly when they had identified potential risks to the safety and potential abuse of children.

Are services effective?

Staff had not received an annual appraisal of their work performance and did not receive regular managerial supervision. Records showed staff had received supervision once in the previous 12 months. There was no system in place to check the competence of staff to administer medicines safely or carry out physical health checks on patients going through assisted withdrawal from alcohol or opiates. Staff did not always follow medicines management policies. Patient records were not always complete or accurate. There were no care plans in place to support staff to care for patients going through alcohol detoxification. Patient care plans did not always address the potential risks to people of early exit from the programme. Most staff had not received training in safeguarding children.

Summary of findings

Are services caring?

Staff were caring and committed to patients using the service. Most patients were positive about the service, particularly the therapeutic groups and individual counselling provided. Patients felt involved in planning their care and treatment and were aware of their care plan. Patients gave feedback about the service at regular community meetings and by completing a satisfaction survey.

Are services responsive to people's needs?

Staff were aware of the needs of different patients and considered whether the service was failing to attract different groups of people. The service did not provide access to an interpreting service directly but encouraged and supported patients to obtain their own interpreter if needed. There was a system in place for managing complaints.

However, patients did not routinely receive written responses to their complaints.

Are services well-led?

The provider had little oversight of the service. It had no proper systems or processes in place to assess, monitor and/or improve quality and safety. It did not collect information that enabled it to identify where improvements could be made. Staff did not undertake clinical audits, or when they did, they did not record the results.

Summary of findings

What we found about each of the main services at this location

Substance misuse services

The service was not safe. There were no detailed written protocols in place in respect of assisted alcohol or opiate withdrawal to enable staff to provide safe and appropriate care and treatment to a patient withdrawing from alcohol or from opiates. Staff did not carry out regular physical health checks on patients undergoing alcohol detoxification in order to identify withdrawal symptoms and any physical health concerns. Most staff did not have sufficient training to be able to provide safe care to patients undergoing assisted alcohol withdrawal or opiate detoxification. Patient risk assessments did not always identify risks associated with patients' mental health. The provider had not conducted proper checks on staff before they were employed to ensure that suitable people were working in the service and patients were not put at risk. The training requirements for different staff roles in the service had not been assessed. Mandatory training was limited to two areas and did not cover all basic responsibilities staff undertook. There were no set timescales for refreshing or updating training to ensure it remained current. There were no proper systems in place to monitor the safety of the environment. The service had not had a fire risk assessment since 2012. Fire drills had not been carried out at the premises. The service had not conducted an infection control risk assessment or audit in the last 12 months. Staff had not always acted promptly when they had identified potential risks to the safety and potential abuse of children.

Staff had not received an annual appraisal of their work performance and did not receive regular managerial supervision. There was no system in place to check the competence of staff to administer medicines safely or carry out physical health checks on patients going through assisted withdrawal from alcohol or opiates. Staff did not always follow medicines management policies. Patient records were not always complete or accurate. There were no care plans in place to support staff to care for patients going through alcohol detoxification. Patient care plans did not always address the potential risks to people of early exit from the programme. Most staff had not received training in safeguarding children.

Staff were caring and committed to patients using the service. Most patients were positive about the service, particularly the therapeutic groups and individual counselling provided. Patients felt involved in planning their care and treatment and were aware of their care plan. Patients gave feedback about the service at regular community meetings and by completing a satisfaction survey.

Staff were aware of the needs of different patients and considered whether the service was failing to attract different groups of people. The service did not provide direct access to an interpreting service but encouraged and supported patients to obtain their own interpreter if needed. There was a system in place for managing complaints. However, patients did not routinely receive written responses to their complaints.

There were no proper systems or processes in place to ensure the quality and safety of service was assessed, monitored and/or improved. There was no robust information collection and management system in place. No meaningful information was collected about the service which made it difficult to identify where improvements were needed or could be made. Clinical audits did not take place or when they did they were not recorded. There was little oversight of quality and safety from the provider.

Summary of findings

What people who use the location say

Most patients were positive about the service. Staff were described as caring, responsive and knowledgeable. They always had time to listen to patients' concerns. Everyone said they had had a care plan in place since admission and felt the plans reflected their views. Patients said they had been helped to prepare for discharge and described the help they had received with housing and benefits in particular. Patients said it was helpful that staff were also in recovery from addictions and understood the kind of things they were going through. However, two patients told us they had not seen a doctor since they were admitted to the service. One patient said that staff were not equipped to support patients going through alcohol detoxification and inadequate medical support had been provided. They said that a patient had been lying on a sofa in the communal area sweating profusely and feeling nauseous for several days. Another patient said that they had called an ambulance because they had felt unwell. They had not felt supported by staff to obtain medical assistance. One patient said they had signed a consent form when they arrived at the service but did not remember much about it. They were unhappy they did not have access to their mobile phone.

We looked at 12 completed patient feedback forms from 2015. They were all very positive and complimentary about the service and particularly the groups and individual counselling provided.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are detailed protocols in place addressing the needs of patients requiring assisted withdrawal from alcohol or opiate detoxification so that staff are supported to provide safe care and treatment and patients are not put at risk of serious harm.
- The provider must ensure that patients admitted for detoxification from alcohol or opiates have an individual care plan in place. This must detail the care and treatment that staff must provide to ensure risks to their health and safety are managed appropriately.
- The provider must ensure that there are clear, written admission and exclusion criteria in place so that patients who cannot be cared for safely at the service are not admitted.
- The provider must ensure that the mandatory training it provides is sufficient to support staff to carry out their role safely and effectively and is refreshed at regular intervals to ensure staff can carry out their responsibilities safely.
- The provider must ensure that all staff have regular supervision and an annual appraisal.
- The provider must ensure that staff who carry out physical health checks on patients are competent to do so and understand when they need to escalate concerns.
- The provider must ensure that staff are aware of and follow medicines management policies and are competent to administer medicines safely.
- The provider must ensure that accurate and complete records are maintained about the care and treatment of each patient.
- The provider must ensure that there are robust systems in place to safeguard children of people using the service and that staff act on concerns identified in relation to the safety and potential abuse of children.
- The provider must ensure that an environmental risk assessment, an infection control audit and a fire risk assessment are carried out at the service to ensure the premises are safe and any identified risks are managed appropriately.
- The provider must ensure that checks on staff are carried out before they start working in the service to ensure they are suitable to work with patients.

Summary of findings

- The provider must ensure that effective systems to assess and monitor the quality and safety of the service are in place.

Action the provider SHOULD take to improve

- The provider should ensure that fire drills are carried out at the premises on a regular basis.
- The provider should ensure that patient risk assessments identify risks associated with patients' mental health and that plans to address these risks are put in place.
- The provider should ensure that clinical audits are carried out and recorded in order to enable staff to learn from the results and make improvements to the service.
- The provider should ensure that patient care plans address the potential risks to patients of early exit from the programme.

PCP Clapham

Detailed findings

Services we looked at:
Substance misuse/detoxification

Our inspection team

Our inspection team was led by:

Team leader: Judith Edwards, Care Quality Commission.

The team that inspected the service on 6-7 May 2015 consisted of five people, one expert by experience, an inspection manager, an inspector and a senior nurse specialising in substance misuse services.

The team that conducted a further inspection visit on 29 July 2015 consisted of three inspectors and a consultant psychiatrist who specialises in substance misuse.

Background to PCP Clapham

PCP Clapham is provided by PCP (Clapham) Limited.

The service provides a substance misuse service using the 12 step model of abstinence. PCP Clapham provides a day service to patients. Patients sleep at one of the provider's other services nearby at night and these locations are registered separately. Patients have an average length of treatment of about 12 weeks. Primary treatment is 12 weeks in duration. The provider told us that 30% of referrals come from specialist drug and alcohol teams and other substance misuse services. The other 70% of patients are privately funded. PCP Clapham provides alcohol and opiate detoxification for patients if needed. A small minority of patients were admitted for detoxification.

PCP Clapham can accommodate nine or ten patients attending the full time therapeutic day programme. Patients who had attended the programme could come back to the service to attend groups on one day a week as part of an after-care package. On the days of the inspection there was one patient admitted to the service. Four patients attended the service as part of the aftercare programme and others attended the service on an ad hoc basis.

We have inspected PCP Clapham three times since 2010 and reports of these inspections were published between April 2013 and September 2013. At the time of the last inspection PCP Clapham was meeting essential standards, now known as fundamental standards.

Why we carried out this inspection

We inspected this service as part of our in-depth inspection programme.

How we carried out this inspection

To get to the heart of 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?

Detailed findings

- 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 service and asked other organisations for information.

During the inspection visit on 6-7 May 2015 the inspection team:

- spoke with seven patients, including one patient admitted to the service at the time;
- spoke with the manager of the service;
- spoke with seven staff working in the service;
- looked at care and treatment records of eight patients;
- reviewed the employment records of 10 staff;
- looked at service feedback forms completed by 12 patients in 2015;
- observed how staff were caring for people;
- attended and observed a multi-disciplinary team meeting;
- observed a community meeting of patients and staff;
- carried out a specific check of medication management in the service;
- spoke with the GP supporting the service;
- spoke with a commissioner of the service; and
- looked at a range of records and documents relating to the running of the service.

During the inspection visit on 29 July 2015 the inspection team:

- spoke with the manager;
- spoke with two staff members, a nurse and a counsellor;
- spoke with three patients admitted to the service;
- looked at care and treatment records of five patients;
- looked at records and documents relating to the running of the service.

Is the service safe?

Our findings

Safe and clean environment

- There was an infection prevention and control policy in place for the service. The registered manager was required to carry out a risk assessment to determine the risks of infection. However, the manager confirmed this had never been done. There was no paid cleaner for the service. General cleaning was carried out by staff and patients. There had been no 'deep clean' of the premises in the last two years. Urine testing was carried out on a very low level shelf in the toilet, which meant there was an increased risk of spillage. Disposable gloves were available for staff but there were no aprons on site.
- The service was generally clean and free from clutter. There were spillage kits available for staff to use and these were within the expiry date. Staff completed an environmental checklist daily. This covered checks on general levels of tidiness, water temperatures, cleanliness of the toilets, whether smoke alarms worked properly and any repairs needed.
- The registered manager confirmed that no environmental risk assessment had been carried out since the service opened in 2012. There was a blank environmental assessment template available to use for this purpose in the provider's health, safety and welfare at work policy document, but it had not been completed. The manager was unable to confirm whether or not there were any environmental risks to staff, patients or visitors.
- There had been a fire risk assessment of the service in May 2012. This listed 11 actions that needed to be carried out to ensure fire risks were managed appropriately. The registered manager was unaware whether these had been actioned or not. No further risk assessment had been conducted. The document stated that the fire risk assessment should be reviewed annually, but this had not happened. There was a risk that potential fire risks were not identified and not safely and appropriately managed.
- There was no identified clinic room and no emergency equipment was kept in the service. There was a first aid kit for use in the event of minor injuries. Staff called emergency services when a patient's health deteriorated.

Safe staffing

- The service operated from 9.00am to 5.00pm from Monday to Friday. On Saturday and Sunday the service was open for half a day. On weekdays there were two or three counsellors working in the service as well as a volunteer support worker. At weekend sessions there was one member of staff present in the service. There was an administrator who worked every day from Monday to Friday. There were no staff vacancies.
- During our first visit to the service we found there were no nurses employed at the service. However, the provider subsequently employed a full-time nurse, working from Monday to Friday, who started working at the service on 13 July 2015. A local GP had been contracted to provide medical advice and support. The GP conducted assessments of patients when they were admitted and prescribed medicines.
- The training requirements for different staff roles in the service had not been assessed. Mandatory training was limited to two areas and did not cover all basic responsibilities staff undertook. There were no set timescales for refreshing or updating training. The manager told us that staff were required to complete on-line training in safeguarding vulnerable adults and the safe administration of medicines. The manager was unaware how often this training needed to be updated or refreshed. No child safeguarding training was undertaken by any staff except the manager. Some patients went through alcohol or opiate detoxification when they were admitted to the service. Staff did not receive specialist training in how to monitor patients undergoing detoxification and make sure this was managed safely.
- During our visit to the service on 29 July 2015 the manager told us that the medicines training for staff was being reviewed to ensure it met the needs of non-nursing staff working in the service.
- The manager did not carry out checks on the competence of staff to administer medicines safely and effectively. The manager did not check the competency

of staff to monitor the physical health of patients undergoing detoxification from alcohol or opiates. There was a risk that staff lacked the skills they needed to care for patients safely. However, a nurse had been employed in the service two weeks before our visit to the service on 29 July 2015. He had taken over responsibility for the administration of all controlled drugs and other medicines being administered to patients during the day from Monday to Friday.

- We reviewed the employment records of ten staff including counsellors, volunteer support workers, volunteer counsellor, peer support worker, manager and administrator. We found the provider had not carried out appropriate checks on staff before they started working in the service to ensure they were suitable to work with people who were potentially vulnerable. We had concerns about the references obtained for seven of the ten staff. For three staff only one reference had been obtained rather than the required two. For two staff two references had been obtained but not until after they started working in the service. Two of the references in the files were undated and one was not on an employer's letterhead. For one person there was no reference obtained from a current employer and no written explanation for this. This meant the provider had not obtained evidence of satisfactory conduct in previous employment for all staff before they started work.
- Criminal history and record checks had been carried out with the Disclosure and Barring Service (DBS) for all staff. However, three of the DBS checks were dated after the staff member had started working in the service. The employment histories of three staff had gaps. There were no written explanations of the gaps in any of their employment files. The provider had not conducted proper checks on staff before employing them and patients had potentially been put at risk.

Assessing and managing risks to patients and staff

- The service provided alcohol and opiate detoxification for some patients but this was not being provided in a safe way. The manager told us that there were no specific policies or protocols in place addressing the needs of patients undergoing detoxification from alcohol or opiates to ensure this was carried out safely. This was contrary to national guidance and meant risks were not managed safely and appropriately.
- On our visit to the service on 19 July 2015 we found that a short paragraph had been added to the standard operating procedure for the management of medicines including controlled drugs since our visit in May. This stated that staff should complete a SADQ (severity of alcohol dependence questionnaire) and CIWA-Ar (clinical institute withdrawal assessment of alcohol scale, revised) before a patient started the detoxification regime. Patient records confirmed that the SADQ and CIWA-Ar were completed at this stage of the admission.
- The standard operating procedure went on to say this should be repeated for "a minimum of three days" or until a score of eight or below was achieved. For drug detoxification the document stated that the COWS (clinical opiate withdrawal scale) should be completed at any time during the detox when" withdrawal symptoms are reported or observed." However, the manager told us that the document was still under review and likely to change so he had not shared it widely with the staff. Four staff including the manager and the nurse had signed to show they had read the policy. This was less than half the staff in the service.
- We reviewed six records of patients who had undergone alcohol detoxification since January 2015. Staff had usually completed a severity of alcohol dependence questionnaire (SADQ) and withdrawal assessment form (CIWA-Ar) for patients when they were admitted to check for withdrawal symptoms. However, they did not carry out any further physical health checks to monitor withdrawal symptoms during the period of detoxification.
- On 6 May 2015 we reviewed the care and treatment records of four patients who had undergone alcohol detoxification at the service from January to May 2015. Patients had been assessed by a doctor on admission. However, for one patient only their height and weight was recorded and for another only their height, weight and blood pressure. None of the four had received any follow up clinical observations or health checks during their admission.
- Records of a patient admitted for alcohol detoxification in July 2015 showed that their height, weight and blood pressure had been recorded. The risk assessment and management plan for the patient was blank and there were no instructions for staff on how, or how often, they should assess and monitor the patient.

Is the service safe?

- Records for another patient admitted in July 2015 showed that they had been assessed by a doctor on arrival at the service. The patient's height, weight and blood pressure were recorded and a SADQ completed. The assessment noted the patient was "going into DTs" (delirium tremens – a serious form of alcohol withdrawal that can result in death). The "actions required by PCP staff" section of the assessment form stated: "will require residential detox for 10 days. Will require supervision." There were no further written instructions for staff on how they should assess or monitor the patient during the period of detoxification. There was no care plan in place to support staff to care for the patient safely. The records showed that the condition of the patient deteriorated during the night and the patient was taken to A&E by ambulance.
- Since June 2014 there had been three recorded incidents of patients having a seizure at the service during detoxification.
- Other than the nurse employed at the service, staff had not received training in how to manage alcohol or opiate detoxification safely. This was contrary to national clinical guidelines which state that staff caring "for people in acute alcohol withdrawal should be skilled in the assessment and monitoring of withdrawal symptoms and signs" (NICE guidelines [CG100] alcohol–use disorders: diagnosis and clinical management if alcohol-related physical complications.)
- The doctor and staff stated that they communicated regularly about patients but there were few records to confirm this actually happened. There were insufficient regular checks on patients undergoing detoxification, particularly during the first 72 hours of assisted withdrawal. As a result they were put at unnecessary risk.
- Patients signed a written treatment contract. By agreeing to take part in the programme of treatment patients consented to bag searches, reduced access to the telephone during the first week and restricted access to their money.
- There was a flow chart on the staff office wall outlining the roles and responsibilities of staff in respect of safeguarding concerns. The manager told us that referrals had been made to the local safeguarding team when appropriate.
- There was a lack of effective systems in place to protect the children of service users from the possibility of abuse. Other than the manager, staff had not completed training in safeguarding children. There was no formal policy on child visitors to the service. The care record of a patient who had children did not make clear who was looking after the children, and there was no information about contact arrangements. In eight care records we reviewed two referred to patients' children but there was no evidence that concerns or questions identified about the children's care and safety were followed up by the service. This was contrary to national guidance. Drug misuse and dependence: UK guidelines on clinical management [Orange Book] identifies staff members' responsibility to the children of patients and the need to assess safeguarding concerns: "they need to take systematic steps to ensure that they assess risk to children (such as making sure that detailed knowledge of a patient's children and risks to them are ascertained as part of all assessments). If a clinician suspects a child may be at risk they must take steps, if necessary immediately, to deal with that risk" (p.22).
- The service kept stocks of medicines, including controlled drugs such as methadone, diazepam, buprenorphine and chlordiazepoxide. We checked the treatment records of five patients who had been administered stock medicines for detox, namely diazepam and chlordiazepoxide. There was evidence that a doctor had carried out an assessment and written a private prescription for four of the five patients before the stock medicines were administered.
- For one patient, three doses of chlordiazepoxide were administered by PCP Clapham staff on 02 March 2015. The doctor's handwritten assessment of the person was dated 03 March 2015. An entry in the person's electronic progress notes said that staff had administered the medicines on 02 March 2015 in line with the doctor's orders. Staff told us the doctor had carried out an assessment on 02 March 2015 on the telephone. The doctor then assessed the person face to face on 03 March 2015 and wrote a prescription for chlordiazepoxide. There was no prescription or written authority for the doses administered on 02 March 2015.
- The provider told us that a doctor always assessed patients in person before writing a prescription authorising stock medicines to be administered.

Is the service safe?

However, other staff told us they occasionally administered stock medicines to patients after a telephone assessment if the doctor was not available, and this was followed up by an email. Staff could not find an email for the chlordiazepoxide administered on 02 March 2015. The service was not following the PCP Clapham medicine policy or national guidance on prescribing/administering medicines.

- A prescription for one patient from their own GP listed they were taking three medicines. However, their medicines administration record listed two. Staff were only administering two of the three prescribed medicines. Three members of staff, who were involved in this patient's care, were not aware that the patient had been prescribed a third medicine, thiamine, and could not explain why this medicine was not listed on their medicines administration record. One member of staff thought it may have been stopped, another member of staff thought that the patient had not collected it from the pharmacy. The patient told us that they were keeping and self-administering this medicine. There was no record of this, and a self-administration risk assessment of the patient had not been carried out. This was contrary to the provider's policy.
- The medicines administration record for the patient using the service had been handwritten by staff, but there was no recorded second person check for accuracy. Staff confirmed that no second person check had been carried out. This was contrary to the provider's medicines policy which stated that medicines administration records should be checked by a second staff member. They had also not identified that only two of three prescribed medicines were recorded on the medicines administration record.
- When we checked supplies of the patient's medicines, there was a discrepancy with one medicine. Staff had recorded that they had received 56 tablets of propranolol 40mg into the service on 24 April 2015. They had recorded that they had administered 25 of these tablets. However there were 33 tablets remaining, indicating that only 23 tablets had been administered. The patient said they had received all of their medicines.
- On 6 May 2015 we found one bottle of a Schedule 2 controlled drug in the medicines cupboard, methadone hydrochloride 1mg/1ml x 500ml. This was not recorded in the controlled drug register or on the controlled drug weekly stock check sheets. There was a despatch note which showed that this medicine was despatched to PCP Clapham on 06 December 2013, and had been ordered by the contracted GP. Staff did not know why this controlled drug was not recorded in the register. It was added to the register on the day of the inspection. Controlled drug weekly stock checks were carried out by the service receptionist, who had received some training in the safe administration of medicines, but was not aware that methadone was a controlled drug. Other staff had been accessing the medicines cupboard twice a day to administer medicines to patients but had not noticed that the methadone was not recorded in the controlled drug register or being stock-checked. This was contrary to the provider's policy on the handling of controlled drugs.
- The inpatient using the service on 6 May 2015 was not prescribed any night-time medicines, so received their medicines between 9am and 5pm at PCP Clapham. Two members of staff told us that when a patient required night-time medicines, they dispensed the night-time doses of medicines into a small plastic bag and took this over to the residential house. This was a separate location and registered separately with CQC. The provider's medicines policy stated that medicines should be administered from the original container. Therefore, staff were not following agreed policies and this increased the risk that patients would receive incorrect medicines.
- Staff were unable to tell us how they would observe for under or over-medication of patients.
- At the visit to the service on 29 July 2015 we found that two new medicine storage cupboards had been installed. The newly employed nurse had taken responsibility for all matters related to medicines. Arrangements for the recording and administration of controlled drugs had improved. The medicines management policy was being reviewed.

Track record on safety

- The service had recorded seven incidents in the service since January 2014. Three of these involved patients suffering a seizure, two patients having slips or falls, one patient experiencing serious physical health problems and one patient going absent.

Is the service safe?

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents.
- The manager provided some examples of learning from incidents that had taken place.

Is the service effective?

Our findings

Assessment of needs and planning of care

- An initial pre-assessment of patients took place either face to face or over the telephone. On admission to the service counselling staff carried out a more in-depth assessment. If a person was seriously incapacitated through alcohol or drugs on arrival an ambulance was called and the team liaised with the local acute hospital.
- Assessments included contacting the patient's own GP to get a summary of medicines they were being prescribed and checks on medicines they had brought with them. Patients completed a severity of alcohol dependence questionnaire.
- The manager told us that if there were serious concerns about a person's mental health on admission they were referred back to their current support team. In the records reviewed we identified three patients with known mental health needs. Two of the three patients had made suicide attempts in the past. However, there was no evidence in their records that staff had attempted to contact their mental health team for further information.
- Most patients had care plans in place. These addressed most of their assessed needs. However, early exit from the programme and the risks this involved were not addressed in four of the care plans we reviewed.
- The service provided individual counselling and groups based on the 12-step model of recovery.
- Patients were registered with a local GP practice during the time they were using the service. This was the same practice where the contracted GP was based.
- The recording of information about patients' care and treatment was very inconsistent. There were many gaps in recording and entries in care records were sometimes out of date order. For example, for one patient who had been admitted a month ago, staff had made entries in their progress notes on eight occasions. Three entries had been made on one day. No entries had been made on the other 22 days of their admission. Progress notes were generally very brief and there were gaps in all eight records we reviewed.
- We reviewed day to night handover notes from April and up to 5 May 2015. There were no records available for 22 days in that time period. Entries were out of date order and difficult to locate in the file in which they were kept. Records of night staff to day staff handovers were better maintained. However, there were no records for three days in April. Staff reported that handovers took place at every shift change.

Best practice in treatment and care

- The GP considered NICE guidelines when prescribing medicines to support patients undergoing detoxification. Staff used cognitive behavioural therapy, anger management, motivational interviewing and other evidence based therapies in groups and in individual counselling sessions.
- However, some national guidance, ((NICE guidelines [CG100] alcohol–use disorders: diagnosis and clinical management if alcohol-related physical complications; and Drug misuse and dependence. UK guidelines on clinical management", 2007 clinical guidelines) was not being followed. For example, there were no local protocols covering the safe detoxification of patients and the majority of staff were not skilled in the assessment and monitoring of withdrawal symptoms and signs
- The service attempted to measure outcomes for patients using treatment outcome profiles (TOPS forms). These recorded a patient's average amount and days of substance misuse in the last four weeks. However, the data were not being used to support improvements in the service or demonstrate the effectiveness of the programme. The staff and manager could not access the national drug treatment monitoring system website in order to review data from the TOPS forms, which would have provided some information on outcomes. The manager was unable to say how many patients had used the service in 2015. He could not tell us how many patients had completed or dropped out of treatment and did not record or hold that information.
- Prior to the inspection the provider had sent us a list of clinical audits regularly carried out by staff. During the inspection we asked to see some examples of these audits. However, the manager told us he was not aware of any of the audits stated and could only provide a copy of an environmental check list. This was filled in

Is the service effective?

every week by staff and recorded checks on general levels of tidiness, water temperatures, cleanliness of the toilets, smoke alarms and any repairs needed. There was no evidence that any clinical audits had been carried out in the service.

Skilled staff to deliver care

- The manager told us that counsellors received supervision monthly and volunteers bi-monthly. However, there were no records to confirm supervision had taken place as frequently as this. When we reviewed the contents of staff files we found one record of a recent individual managerial supervision session in each of seven files even though some staff had been working at the service for many years. The manager said that supervision had been taking place but had not been recorded until very recently. The provider's policy stated that supervision should happen bi-monthly with staff. In one supervision record dated March 2015 a staff member had identified themselves as 'requiring improvement' in terms of practising safely. There was no record that this had been taken any further by the manager.
- There was no evidence that staff had ever received an annual appraisal of their work performance. The manager confirmed that this was the case.
- Counsellors were trained and had higher level degrees in addiction counselling.
- The GP contracted to the service had recently trained staff how to use the blood pressure monitor. Staff told us they had not yet used the monitor.

Multi-disciplinary and inter-agency team work

- There was a daily multi-disciplinary meeting involving counsellors and support staff.
- The manager said it could be difficult to liaise with community mental health teams and crisis teams, but attempts were made to involve them where possible. Patients did not necessarily live in the local area.

Good practice in applying the MCA

- Staff made an assessment of mental capacity of each patient when they arrived at the service. They were not formally admitted until they were sober enough to have capacity and give informed consent to admission. A person who was moderately drunk on arrival was assessed by the contracted GP.

Is the service caring?

Our findings

Kindness, dignity, respect and support

- Staff were caring.
- Most patients were very positive about the service. Staff were described as caring, responsive and knowledgeable. They always had time to listen to patients' concerns.

The involvement of people in the care they receive

- All care plans we reviewed were signed by the patient to show they had read and agreed with the plan. All patients we spoke with said they had a care plan and this had been in place since admission. Patients felt the plans reflected their views.
- Patients could raise any concerns about the service or premises at weekly community meetings. Minutes of recent meetings showed that patients had raised concerns about a leaking fridge and lights not working and these had been addressed.
- Carers often visited the service when the patient had completed the programme successfully.
- Patients were encouraged to give feedback about the service using a questionnaire. We reviewed 12 questionnaires completed in 2015. These showed that patients were very happy with the service they had received and asked for more therapeutic groups to be provided.

Is the service responsive?

Our findings

Access and discharge

- The service gave clear information on the cost of treatment programmes before a patient was admitted. The provider told us about 70% of patients using the service were funding their own treatment. Beds were sometimes commissioned by other services and commissioners.
- There was one inpatient using the service at the time of the inspection. The service could accommodate nine or ten patients and could admit patients at short notice.
- The service linked with housing providers to support patients with accommodation needs when they completed the programme or left the service.
- Staff helped patients identify recovery meetings they could attend in their local area once they were discharged.
- The service commissioner we spoke with was positive about the service and said communication with staff had been very good. The service had responded promptly to all requests for information.
- The service could provide no information on patients' average length of stay in the service. A programme of treatment lasted 12 weeks and could involve a further 12 weeks if the patient wished.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients were encouraged to be as independent as possible within the structure of the programme. Lunch was provided by the service. Outside of the programme patients were supported to budget and buy their own food and prepare meals. This was provided in the two other houses provided by PCP (Clapham) Limited. These are registered with CQC as separate locations.
- The premises were light and airy and there was access to a garden at the rear.
- There were rooms available for individual and group therapy.

Meeting the needs of all people who use the service

- The manager had identified, through research, that gay men were more than seven times likely to abuse alcohol than non-gay men. However, they were under-represented in terms of patients using the service. He was exploring factors that affected their entry into the service. The manager told us of one patient who had asked for a gay counsellor and the service had provided this.
- A room was available in the service for people who wished to pray.
- The service had admitted patients who did not speak English in the past. It was the responsibility of the patient or referrer to obtain someone to interpret for them in these circumstances.

Listening to and learning from concerns and complaints

- Information on how to make a complaint about the service was on display in the communal area.
- The service had recorded four complaints in the last 12 months. Records of the complaints showed that these had been investigated, the manager had responded to the complainant and complainants had been mostly happy with the outcome. However, there were no records of any written responses to complaints.
- Complaints were shared with the staff team so that learning could take place. Suggestions made by patients were also recorded along with the actions taken to improve the service.

Is the service well-led?

Our findings

Vision and values

- The service had a culture statement that set out the vision and values of the provider and the service. Staff acted in accordance with the culture statement. Most staff themselves were in recovery and committed to the 12 step recovery model and the values embedded within this.

Good governance

- There were no proper systems or processes established or operated to ensure the quality and safety of the service was assessed, monitored and/or improved. Risks in relation to the environment, infection control and fire were not assessed, monitored or mitigated. A fire risk assessment had not been carried out since 2012.
- Contemporaneous records in respect of each service user, including information about their care and treatment were not being maintained consistently and accurately. There were significant gaps in patient care and other records and many days on which no information had been recorded about a patient.
- No information was routinely collected about admissions or use of the service. It was therefore very difficult to identify where improvements were needed or could be made. The manager told us he had concerns about medicines management and documentation in the service but had not conducted any audits or checks of these areas. There were no regular clinical audits undertaken.
- Prior to the inspection the provider had sent us a list of 23 audits which they said had been conducted in the service. They stated we would be able to view the audits during the inspection. The list included audits of care planning, client files, staff supervision and appraisal, staffing levels and medicines. When we asked the manager whether we could see these audits he said he was not aware of any of them. The manager said he undertook checks of care records but kept no records of this.
- A quality assurance meeting was held by the provider every six months. This involved the registered managers at all the provider's services, which were spread across the country. The meeting allowed managers to share information and good practice which could lead to improvements in the services.

Leadership, morale and staff engagement

- The manager had recently completed a leadership course, which he said had helped improve his knowledge and skills.
- The manager and staff reported that staff meetings were held monthly. We saw minutes from two meetings in 2015 and one set of minutes for a meeting in 2013 but there were no records of meetings in 2014.
- The manager stated that no staff surveys had been carried out to find out the views of staff about the service and/or their role.
- Some staff told us it was difficult to suggest improvements as these were not always well received by the manager. They did not always feel listened to and their ideas were not taken seriously.
- The manager had infrequent contact with the provider and was largely unsupported in his day to day management role. The manager was fully engaged in providing individual and group therapy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way: The provider had not ensured that the premises were safe to use. The provider had not assessed the risk of infection or considered ways to mitigate any such risk Medicines were not always managed properly and safely. This was a breach of regulation 12(1)(2)(a)(b)(d)(h)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes established to assess, monitor and improve the quality of the service were not operating or were not effective. The provider had not ensured that accurate and complete records were maintained in respect of each patient . The service did not have effective systems and processes in place to ensure safeguarding concerns in respect of children living with or related to patients were followed up by staff. The provider had not ensured children were properly safeguarded. This was a breach of regulation 17(2)(a)(b)(c)(e)(f)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Staff employed by the service did not receive appropriate support, training, supervision and appraisal to enable them to carry out their duties safely and effectively.

This was a breach of regulation 18(1)(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not effective. The provider had not ensured all staff were of good character and safe to work with patients before they started work in the service. This was a breach of regulation 19(1)(2)(3)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way: The risks to patients undergoing assisted alcohol withdrawal were not being assessed and monitored appropriately through the period of withdrawal. The provider had not done all that was reasonably practicable to mitigate the risks to the health and safety of patients undergoing alcohol or opiate detoxification. The provider had not ensured that staff were competent to manage alcohol and opiate detoxification safely. This was a breach of regulation 12(1)(2)(a)(b)(c)