PCP Clapham

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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

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

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

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

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- The service had made improvements since our last comprehensive inspection in May 2015 and our focussed re-inspection in December 2015 and they were focussed on continuing to improve.
- The service had written protocols in place in respect of assisted alcohol or opiate withdrawal for clients. The staff were familiar with the protocols and had been trained to use them in the management and treatment of clients withdrawing from alcohol or opiates. Care plans addressed the needs of clients going through alcohol detoxification.
- The service had made improvements in their admission process since the last inspection. Clients completed a pre-admission screening checklist. Staff undertook an assessment of client needs. At the last inspection, we found that the service's assessment of client risk prior to admission was not robust. During this inspection, we found that the service obtained information prior to admission and now undertook a thorough and holistic assessment of risk. Staff reviewed risk on a regular basis and took action to manage client risk.
- Since the inspection in May 2015, all staff had been trained in safeguarding adults and had a good

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understanding of how to raise a safeguarding alert. The majority of staff had been trained in safeguarding children. The staff had an understanding of the risks posed to children and young people.

- At the inspection in May 2015 we found that the service was not obtaining disclosure and barring checks for their employees. Additionally the provider had not explored the gaps in staff members' work histories. The provider could not be assured that employees were safe to work with the clients. Since that inspection, the service had obtained disclosure and barring checks for their permanent employees. The provider now also explored the gap in prospective employees' work histories during the interview process.
- At the inspection in May 2015, we found that there were not proper systems to monitor the safety of the environment. During this inspection, we found that staff completed an environment checklist. The checklist had been completed regularly since November 2016. The service undertook regular fire drills.
- Since the last comprehensive inspection, the service had made improvements in providing supervision to staff and completing annual appraisals. Staff received regular managerial and clinical supervision. Staff had appraisals. The service had a range of skilled staff including doctors and nurses.
- When the service was inspected, in 2015, we found that there were no systems in place to check the competence of staff who administered medicines. Staff were not always following medicines management policies. We found the service had made improvements since that time and provided training for staff in the administration of medicines. Staff had been observed undertaking this task to ensure that they were competent and able to do it safely. The service had appropriate arrangements for obtaining medicines for clients.
- Staff were caring and committed to the clients who used the service.
- The provider had made improvements to their complaints handling system since the last comprehensive inspection and employed a member of staff to deal with complaints. Complainants received written responses to complaints.
- At the last inspection in May 2015, we found that the provider had little oversight of the service and had no proper processes to monitor and improve quality and safety. At this inspection we found that the provider had improved their clinical governance processes. Senior staff attended regular clinical governance meetings and had undertaken a number of audits which were clearly recorded. There had been some improvements in the quality of care plans as a result of these audits.

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

- At the last inspection in May 2015, we identified that there were no up to date training records for staff working in the service. At this inspection, we found that there were now training records but not all staff had completed their mandatory training. Training completion rates were low (70%) and some members of staff had not updated their mandatory training. The provider had not matched the training requirements to the staff members' roles and responsibilities.
- There was a lack of records confirming that staff had calibrated the equipment used for physical health monitoring and there were no records of when the equipment had been cleaned. The service could not provide assurance that the equipment was safe or clean to use. During this inspection, we found that the clinic room was not clean. There were areas in the clinic room that were dusty. This had not been identified when an infection control risk assessment had been completed in December 2016.
- The provider did not have a schedule of when clinical audits should be undertaken. Audits were undertaken on an ad hoc basis.
- Nor had the service obtained Disclosure and Barring Service checks for the doctors who worked in the service. This meant that the provider could not be assured that the doctors did not present a risk to the

clients at the service. The service could not be assured that one of the doctors had undergone re-validation and had demonstrated that they had kept their skills and knowledge up to date.

- The service had one fixed panic alarm in the building. If clients or staff were in other parts of the building they may have had difficulty in summoning assistance.
- The provider's assessment did not consider whether the client had contact with children or adults at risk. There was no consistent process to assess these risks when clients were admitted to the service.
- Not all clients had an unplanned early exit plan. It was not always clear what clients should do if they left treatment early. Clients who have recently undergone detoxification are at high risk of overdose.
- The business continuity plan was not up to date. It should have been reviewed in February 2016. There was a possibility that the guidance contained in the plan might no longer be up to date.

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Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse/ detoxification		Start here...

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Background to PCP Clapham

PCP Clapham is provided by PCP (Clapham) Limited which is the parent company. The service provides a substance misuse service using the 12 step model of abstinence. PCP Clapham provides a day service to clients with substance misuse problems, including rehabilitation and alcohol and opiate detoxification where needed. Clients sleep at one of the provider's other services nearby at night and this location is registered separately. Clients' primary treatment can last up to 12 weeks. PCP Clapham provides alcohol and opiate detoxification for clients if needed.

PCP Clapham can accommodate up to nine clients attending the full time therapeutic day programme. On day one of the inspection, there were three clients and on day two there were two clients receiving care and treatment.

PCP Clapham is registered to provide the following regulated activity:

Treatment of disease, disorder or injury.

There is a registered manager in place. The service received referrals from statutory agencies and private clients from inside and outside of London.

When we undertook our last comprehensive inspection of the service in May and July 2015, we identified a number of serious concerns. As a result, of the serious concerns identified we served the provider a warning notice under section 31 of the Health and Social Care Act 2008, to stop the provider from admitting clients who required assisted withdrawal from alcohol or opiates until systems and processes were put in place to do this safely. In addition to the warning notice we also issued a number of requirement notices.

The service was last inspected in December 2015. This was a focused re-inspection of the service. The inspection was undertaken to ascertain whether the provider had implemented systems and processes to ensure they were able to provide alcohol and opiate detoxification safely. At that inspection, we found that improvements had been made and as a consequence, we removed the condition we had imposed upon them and deemed that the service was able to resume providing alcohol and opiate detoxification to clients.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspection manager, a specialist advisor who was a nurse that had experience in working with substance users and a pharmacist inspector.

Why we carried out this inspection

We undertook this most recent comprehensive unannounced inspection as part of our national programme of inspections. During this comprehensive inspection, we checked to see whether PCP had met the requirement notices issued during the comprehensive inspection which took place in May and July 2015 but which were not followed up during the focused inspection that took place in December 2015.

Following the inspections of May and July 2015, we told the provider it must take the following actions to improve the service:

- The provider must ensure that each client admitted for detoxification from alcohol or opiates have an

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individual care plan in place. This must detail the care and treatment that staff must provide to ensure risks to each client's health and safety are managed appropriately.
- The provider must ensure that there are clear, written admission and exclusion criteria in place so that clients 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.
- 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 clients 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 client.
- 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 regularly 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 clients.
- The provider must ensure that effective systems to assess and monitor the quality and safety of the service are in place.

These requirement notices related to:-

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How we carried out this inspection

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To understand the experience of people who use services, we ask the following five questions about every service:

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

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

During this inspection we:

- visited the service and looked at the quality of the physical environment
- spoke with the registered manager for the Clapham service
- spoke to the Luton service who provided peer support to the manager of the Clapham service. The Luton service is a sister service which is run by the same provider
- spoke with four staff members employed by the service provider, including the nurse, therapists and the receptionist
- spoke with three clients who were being treated at the service
- looked at seven care and treatment records, including medicines records, for people who used the service
- looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with three clients. Their feedback about the service and staff was mainly positive. They felt that the staff were supportive and had a good understanding of their individual needs. Clients felt that there was a good range of therapeutic input. Clients using the service knew how to complain, and were provided with this information upon admission.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

- The clinic room was not clean. The service's most recent infection control audit had not identified that this posed a risk of infection. The service had not calibrated the physical health monitoring equipment on a regular basis. The records of calibration started on the day before the inspection. The environmental checklist was not being completed on a regular basis there was a six week gap in the records between October and November 2016. The environmental checklist was completed as a means of ensuring that the environment was safe for clients and staff. The provider could not be assured that the environment was safe during that period.
- The service had one panic alarm, which was located in the staff office and accessible to staff only. There were no alarms in the therapy rooms, clients' toilets or in the nurses office.
- The provider had not obtained a Disclosure and Barring Service (DBS) check for the doctors that worked in the service. The provider could not prove that the doctors working in the service were appropriately trained in substance misuse.
- The service did not always ask clients whether they lived with adults at risk or had contact with children or adults at risk.

We found the following areas of good practice:

- The service had a designated clinic room and emergency equipment. The emergency equipment was checked on a regular basis.
- The service had appropriate arrangements for obtaining medicines for clients. Staff were aware of and followed medicines management policies. Staff were competent to administer medicines safely
- The service had a range of skilled staff including doctors and nurses. The staff had been trained in safeguarding adults and had a good understanding of how to raise a safeguarding alert.
- The service had robust detoxification protocols. Staff were aware of the procedures and protocols in place to make sure

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detoxification could be safely provided. Staff had received training in how to care for clients undergoing alcohol and/or opiate detoxification. The provider had trained staff in the safe administration of medicines.

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff had regular managerial and clinical supervision. Staff had appraisals.
- The service kept comprehensive client records, which included plans to manage the range of risks relevant to the client group.
- Clients had access to a range of therapies.
- Staff used recognised assessment tools including opiate withdrawal scales and severity of alcohol dependence questionnaire to measure the severity of withdrawal from alcohol and opiates.

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

- The provider had undertaken a range of audits to improve the service. However, it was unclear how often these should take place and they appeared to be ad hoc.
- The provider had not requested or obtained a Disclosure and Barring Service check (criminal records check) for the doctors that worked at the service. The provider had not requested or obtained revalidation information for one of the doctors.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients were positive about the care and support they received. Clients felt safe.
- Staff understood individual needs and were aware of their preferences.
- Clients' views were reflected in their care plans.

Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

Summary of this inspection

- There was no waiting list for the service. All admissions were planned and the provider had a clear admission criteria, which identified clients that could be offered treatment at the service.
- Staff prepared discharge letters for clients when they had completed treatment and were leaving the service. The discharge letters were sent to the client's home GPs.
- Complaints information was readily available for clients. The provider had made improvements to their complaints handling process as a result from feedback the Information Commissioner's Office.

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

- The service had not formulated robust and comprehensive unexpected exit plans for all the clients. This meant that there was a lack of information readily available for clients who left the service unexpectedly. Clients who have recently undergone detoxification are at high risk of overdose. Unplanned discharge plans ensures that clients are aware of the risks and gives them information as to how best manage the risks.
- The clients felt that there was a lack of physical activities available for them.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Following the inspection in May 2015, where requirements to improve the service were made we found that the provider had made a number of improvements and it was clear that the service was improving its governance systems. The provider now had better oversight of key issues within the service.
- The provider had established a clinical governance group, which met every six weeks. The meeting gave the managers the opportunity to review the activities being undertaken in the service. This included reviewing complaints and incidents and allowed them to identify where improvements needed to be made.

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

- The provider's business continuity plan was dated 2014. The plan should have been reviewed in February 2016. Although the

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information was still relevant, it did not indicate that the provider should notify the CQC of the incident. This meant that there was a risk that in the case of a significant incident, the appropriate actions may not be taken.

- The monitoring of training completion rates was not robust. Some staff had not undertaken updates of their mandatory training.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Nurses, support workers and therapy staff had received training related to the Mental Capacity Act. We saw that there was reference to capacity to consent to admission and treatment in clients' care records.

Clients signed consent forms prior to commencing treatment.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

.Safe and clean environment

- Staff controlled access into the building via an intercom system. This meant that staff monitored those who were either entering or leaving the building. They also kept written records, as visitors had to sign the visitors book. Clients did not have keys to the building and had to let staff know they wished to leave. There was an emergency door release button, which could be used if people needed to leave urgently.
- The manager undertook daily fire checks which were documented and there was regular fire alarm testing. There was a file containing the fire and emergency evacuation plan. The provider ensured that fire exits and evacuation notices were clearly displayed. When the service was inspected in 2015, we found that there was no fire risk assessment. The provider now had one in place and the service has been fire risk assessed in September 2016. The fire risk assessment had not identified any issues that needed to be addressed.
- There was an infection prevention and control policy in place for the service. When the service was inspected in 2015, we found that an infection prevention and control risk assessment had not been carried out. We issued a requirement notice as a result. During this inspection we found that the provider had undertaken an infection control audit and risk assessment. The audit was dated 2 December 2016. The audit identified two remedial actions that needed to be undertaken. The actions related to ensuring that clients were given information regarding good hand washing techniques and some staff being given training on urine specimen handling. At the time of the inspection the provider had not actioned these things.
- The service did not employ a cleaner. The clients undertook the cleaning of the service as part of their therapeutic duties and this was done on a regular basis. The clients were given a list of what needed to be cleaned and chose the tasks they wished to undertake. Staff had oversight of these tasks and ensured that they were cleaned to satisfactory standard by using a checklist. The communal areas of the service were generally clean and free from clutter. The routine cleaning of the clinic was undertaken by staff. The clinic room was not clean. High and low level areas, for example, the top of the drugs cupboard, picture frames and the skirting boards in the clinic room, were very dusty and this posed a risk of infection. The service's infection control audit completed on the 2 December 2016 had not identified that the clinic room was not clean and posed a risk of infection.
- The clinic room was not tidy. Clinical supplies were stored on the floor, this included boxes of drug testing kits and nutritional supplements for the clients. This posed a potential trip hazard.
- There were body fluid spillage kits available for staff to use and these were within the expiry date.
- During the comprehensive inspection in May 2015, we found that the service was not taking adequate steps to ensure that environmental risks were being managed. During this inspection we found that staff now completed an environmental checklist. The records stated that this should be done weekly. However, the manager stated and the records indicated that it was being completed monthly, but there was a six week gap in the records between October and November 2016. This meant that the checks had not been carried out with the frequency that the service had determined was necessary. The environmental checks included checks on general levels of tidiness, cleanliness of the toilets and the contents of the first aid box.

Substance misuse/detoxification

- During the inspection in May 2015, it was noted that urine testing was carried out on a very low level shelf in the toilet, which meant there was an increased risk of spillage. Since that inspection, the provider had moved the shelf to a higher level to reduce this risk. Staff undertaking the urine drug screens for clients had access to gloves, aprons and handwashing facilities. The service had appropriate clinical waste disposal processes.
- When the service was inspected in May 2015, there was no identified clinic room and no emergency equipment was kept in the service. The service now had a designated clinic room and emergency equipment included an automated external defibrillator (AED). An AED is used to diagnose and treat life threatening cardiac problems. The AED had been checked regularly to ensure that it worked and the defibrillator pads were in date. The service ensured that they kept written records of the checks that had been undertaken.
- The service had one panic or call for assistance alarm in the building, which was located in the staff office. Although the service was not particularly large, the toilets and clinic room were located some distance from the staff office and the doors to these rooms were normally closed to maintain privacy and dignity. Clients and staff had no reliable method to summon assistance other than shouting if they were physically unable to find a member of staff to provide them with assistance.
- The service had the necessary equipment to carry out basic physical health checks on clients. Staff had access to weighing scales, an examination couch, blood pressure monitoring equipment and monitors to measure how much alcohol the clients had drunk. There were no cleaning records for the physical health monitoring equipment.
- The service had not calibrated the physical health monitoring equipment on a regular basis. During this inspection we found that there was one record of the equipment having been calibrated and this was dated the 13 December 2016. When we returned for our follow up visit on the 28 December 2016, we noted that the service had started calibrating the equipment on a weekly basis and had records to confirm this. The lack of regular calibration prior to the 13 December of the physical health monitoring equipment, meant that the provider could not be assured that the equipment they were using to undertake the physical health checks on clients was providing accurate readings.
- The service had appropriate arrangements in place for obtaining medicines for clients. Staff had a clear understanding as to how medicines were obtained. There were sufficient quantities of medicines available to enable clients to have their medicines when they needed them. The clinic doctor prescribed medicines on private prescriptions, which were dispensed at a local retail pharmacy. The clinic also had a small stock of commonly prescribed medicines. As part of this inspection, we looked at the medicine administration records for three clients. We saw appropriate arrangements were in place for recording the administration of medicines. The provider carried out weekly checks to ensure the administration of medicine was being recorded correctly.
- The service stored medication securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. Controlled drugs were stored and managed appropriately. Appropriate emergency medicines were available which included Naloxone, which is a drug, used to counter overdose. The provider medication policy had been reviewed in July 2015 and we saw copies of the protocols used in alcohol and opiate withdrawal, which were in line with best practice.

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. The service had a range of staff working to support and treat the clients. On weekdays, there was one counsellor, the registered manager, an administrator and a nurse working in the service. At weekends, there was one member of staff present in the service. There were no staff vacancies.
- There were no unfilled nursing shifts at the service within the last six months at the service. If the permanent nurse was off sick or on annual leave the service requested an agency nurse. There were two agency nurses who were familiar with the service that were used should the occasion arise. The service last

used an agency nurse in November 2016 to provide cover until a permanent nurse was recruited. The permanent nurse had started working at the beginning of December 2016. The nurse worked Monday to Friday during office hours only. If controlled drugs needed to be administered out of hours this was done by one of the support workers or counsellors. All staff had received training.

- The service's doctor conducted assessments of clients when they were admitted and prescribed medicines. They also dealt with general health issues on admission. This doctor and another doctor were on call out of hours.
- Newly appointed staff had a corporate and local induction. The management of the service provided new staff with the relevant policies and undertook an analysis of their training needs. The staff induction pack was comprehensive. Newly appointed staff had the opportunity to shadow more experienced members of staff during their induction.
- Criminal history and record checks had been carried out with the Disclosure and Barring Service (DBS) for all permanent staff. However, the provider had not obtained their own Disclosure and Barring Service (DBS) check for the doctors that worked in the service. This was brought to the attention of the provider who said they would obtain a DBS for the doctors.
- At the inspection in May 2015, we found that the employment histories of three staff had gaps which were not accounted for. The provider had not conducted proper checks on staff before employing them and clients had potentially been put at risk. During this inspection, we found that three members of staff had gaps in their employment history, which were not accounted for. The application form completed by prospective employees did not ask for gaps in employment to be explained. There was no documentation in the staff file which indicated that the provider had explored the reason for the gaps in the employees work history. Two of these members of staff had been employed since our inspection in May 2015 where we had identified these concerns.
- At the inspection in May 2015, we found that the provider had not assessed the training requirements for different staff roles. 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.
- At this inspection, we found that the provider had made improvements. They now had a list of mandatory training that staff were expected to undertake and a system was in place to ensure that staff refreshed their training. However, the provider had not matched the training that was provided, to the roles and responsibilities of the individual staff members. There were 29 mandatory training courses included. The provider recognised that this was an area that needed to be improved. The provider had a small staff team of five. Three members of staff had completed over 80% of their mandatory training, however, one of these members of staff required an update to four pieces of training. One member of staff who undertook the majority of administrative tasks within the service had completed 19 out of 29 mandatory training courses, however, they had undertaken all the training that was relevant to their role and it was the specialist substance misuse training that was outstanding. Another member of staff who worked as a counsellor had completed three out of 29 mandatory training course and had not been trained in safe lone working or cardiac pulmonary resuscitation essentials (CPR). This member of staff undertook lone working at weekends during the day.
- All staff had been trained in safeguarding adults. However, the manager required an update of this training. This should have taken place in August 2016. One member of staff had not been trained in safeguarding children.

Assessing and managing risk to clients and staff

- During this inspection, we found that the service was working in accordance with their policy regarding ensuring that they were addressing the needs of clients undergoing detoxification from alcohol or opiates.
- The service had clear admission criteria. For example, the service would not admit clients who had a history of seizures or a history of violence to others. This was because the service could not manage clients who had these risks. Clients were asked to confirm prior to admission, in writing, that they were able to self-care.

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- Staff searched the belongings of newly admitted clients to ensure that they did not bring anything into the service which might pose a risk. This helped ensure that risks to clients and staff were managed appropriately. The service ensured that they sought the client' permission prior to undertaking these searches and the client's consent was clearly documented on the care records.
- All clients underwent an assessment of their needs and of the risks affecting them before or on admission. Staff assessed the risks in terms of clients' substance misuse, physical health, self-care, mental health and social needs, such as housing. The assessment form included a question asking whether any children lived with the client. However, staff did not record that they had considered if the client had contact with children or adults at risk. Staff we spoke to said that they would ask about whether a client had contact with children or adults at risk during the formulation of the risk management and treatment plan. There was nothing in the assessment documents which prompted staff to ask these questions. There was not a consistent approach to assessing these risks.
- We reviewed seven client treatment records. The records included current clients and clients who had recently completed treatment. Five of the clients had a risk management and treatment plan in place. These varied in the level of detail recorded. For the other two clients there were no specific plans recorded, but a reference as to how risks were being managed was made in the risk assessment document. This included reference to a particular medicine prescribed to treat a physical health problem.
- All the staff we spoke with had a good understanding of safeguarding both adults and children. Staff were able to give examples when they had raised safeguarding concerns with the local authority and they work they had undertaken directly with the client to ensure that they were kept safe.
- Staff completed a self-administration of medicines tool with clients to assess their ability to manage and look after some medicines such as vitamins. All medicine administration records had been completed and signed by staff appropriately. The limits of prescriptions, particularly of medicines taken only when needed, were made very clear. For example, the overall maximum dose that could be administered within a 24 hour period was clearly written on records. Where a client had tried to hide a prescribed medicine, this was recorded on their medicine administration record and staff were asked to be extra vigilant when administering the client's medicines.

Track record on safety

- Since the beginning of January 2016, there had been 34 incidents in the service. The themes of these incidents were mainly trips/ falls, hospital referrals for physical health concerns, medication errors and relapse. The service had thoroughly reviewed the circumstances relating to these incidents and had taken appropriate action. For example, the service had repaired a defective door immediately following one incident in an effort to improve client safety. With regards to the medication errors. There had been three in the last 12 months. The most serious related to a member of staff leaving the premises with the medication safe keys which meant that clients received their medications two hours late. The provider had investigated this and now had a system of logging keys to ensure that staff did not leave the building with them.

Reporting incidents and learning from when things go wrong

- Staff were aware of the procedures for reporting all incidents. Incident recording was via a paper based system. Incidents were initially reported and reviewed by the registered manager. They were responsible for reporting the incident to head office and CQC where appropriate.
- Staff discussed incidents during the daily handover meetings, team meetings and the clinical governance meetings. There was evidence that there was learning from incidents and the managers shared this learning with the staff group. Where the incidents related to a specific member of staff, the provider ensured that this was raised directly with them.

Duty of candour

- Staff were aware of the duty of candour. The duty of candour is a legal requirement, which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. It also involves keeping the client up to date with any

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investigation and the outcome. Staff were aware of the need to be open and transparent when things went wrong. The duty of candour aims to ensure that services learn from mistakes.

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

Assessment of needs and planning of care

- All referrals to the service were handled initially at the provider's head office. Potential new clients were required to complete a pre-admission form. This information was then forwarded to the service. The nurse reviewed the information on the pre-screening form for wellbeing concerns prior to admission. Staff reviewed all potential new admissions during their daily meetings. The service also liaised with the client's home area GP, requested blood tests and other relevant tests as well as requesting GP notes with a list of current medications prescribed. Whenever possible the service tried to ensure that this information was available on admission.
- All clients were physically examined by the service's doctor before treatment was started. The doctor's assessment included a review of the client's presenting physical health, mental state, a record of any diagnosed physical and/or mental health conditions and currently prescribed treatments. The doctor's notes were handwritten and was difficult to read. This meant that mistakes could be made if staff were not able to read what was written clearly.
- The service had robust detoxification protocols and processes. For example, the clients received regular medical reviews from the doctor after admission. The nurse saw the all clients on a daily basis. The nurse ensured that she monitored the clients' physical health on a daily basis.
- The provider used recognised assessment tools including opiate withdrawal scales and severity of alcohol dependence questionnaire (SADQ) to measure the severity of withdrawal from alcohol and opiates and to ensure they received the correct level of medication to assist their withdrawal. There was timely identification of people who were becoming acutely unwell as a result.
- The service provided individual counselling and groups based on the 12-step model of recovery.
- Clients were registered with a local GP practice during the time they were using the service. This was the same practice where the contracted doctor was based.
- At our inspection in May 2015, we found that the recording of information about clients' care and treatment was inconsistent. During this inspection, we found that this area of practice was greatly improved. The records were regularly updated and comprehensive.

Best practice in treatment and care

- Clients had access to a range of therapies provided by the team in the service. Therapies were provided seven days a week. The therapeutic programme included one to one counselling sessions and group work sessions, which focused anger management and substance misuse. Clients were actively encouraged and expected to attend mutual aid organisations, for example, alcoholics anonymous.
- At our last inspection in May 2015, we found that the provider was not undertaking regular audits. It was therefore very difficult to identify where improvements were needed or could be made. Since the last inspection, the provider had undertaken a number of audits. The last audit was in September 2016, which identified a number of improvements that the needed to be made. The audits undertaken in September 2016 had focused on client records, including ensuring that doctors' notes were legible, staff records/training, record keeping for medicines management and clinical governance issues within the service. The service had made some improvements as a result of the audit. However, some issues were still outstanding, including the legibility of the doctors' notes. The service said they would be addressing this. There was no evidence that the service had a routine audit cycle in place and the audits appeared to be ad hoc.

Skilled staff to deliver care

Substance misuse/detoxification

- The service supported clients with a variety of needs and as a consequence needed a skilled workforce. The service employed therapists, support workers and nurses and they were appropriately skilled staff to deliver care. All staff had relevant qualifications. The regular doctor had been undergone revalidation by the General Medical Council. This meant that the doctor had demonstrated that they were fit to practice. However, the provider could not confirm that the other doctor that was used to provide cover out of hours for the service had undergone revalidation. The provider could not prove that the doctors working in the service were appropriately trained in substance misuse.
- Counsellors were trained and had higher level degrees in addiction counselling.
- During our inspection in May 2015, we found that staff were not having regular supervision and they had not received an appraisal. We issued the provider with a requirement notice because of this. Since that inspection, the provider had made improvements. During this inspection, we found that staff were receiving both managerial and clinical supervision regularly. The provider had made efforts to ensure that they employed an external clinical supervisor that was able to meet the needs of the staff employed at the service. Staff said that they felt supported. There was one appraisal outstanding due to the meeting having been cancelled.
- The provider undertook observations of staff undertaking tasks relating to the work they undertook with clients, for example, medicines administration competency and client discharge to ensure that they were undertaking these tasks properly. The observation records noted what had been done and whether the member of staff was competent. However, the observations records were not signed by the person who had undertaken the observation and there was no schedule as to how often these observations should take place. There were dates for review noted on observation records but it was unclear whether the review had taken place. For example, two members of staff had undertaken medication training but there was no observation recorded of them undertaking this task. The provider could not be assured that the members of staff were still competent to undertake these tasks.

Multidisciplinary and inter-agency team work

- Staff had daily meetings at the start of each shift. All of the staff attended these. During the meetings, staff reviewed the actions from the previous meeting to ensure that all actions had been followed up. Staff discussed all the clients using the service and identified what support they required. Potential new admissions were also discussed during this meeting.
- If clients had additional needs, staff in the service liaised with secondary health care services as necessary. For example, when clients needed to attend appointments at local acute hospitals. The staff shared information with these services with the consent of the client. Staff also liaised with the clients' care co-ordinators with regards to discharge arrangements.

Adherence to the MHA

- The service was not registered to accept clients detained under the Mental Health Act. If a client's mental health were to deteriorate, staff were aware of who to contact. Some of the nursing staff were registered mental health nurses and were aware of signs and symptoms of mental health problems.

Good practice in applying the MCA

- The majority of the staff had completed training in the Mental Capacity Act (thee staff out of five). Staff made an assessment of mental capacity of each client 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. The service asked all clients to sign a consent form prior to them commencing treatment.

Equality and human rights

- The provider offered training in equality and diversity and emphasised the importance of accepting all individuals.
- The service was open to men and women had a mixed gender and mixed ethnicity staff group.
- Blanket restrictions were in place at the clinic and all clients had consented to these. These restrictions were in place to ensure the safety of clients and were outlined in the treatment contract that was signed by clients. The treatment contract was also reviewed at every community meeting which was attended by the clients. These restrictions included attending therapeutic

groups, consenting to give samples for drug and alcohol tests and not purchasing over the counter medicines. Clients were informed that they might be discharged should they not comply with these restrictions.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- The clients using the service were positive about the care and treatment they had received. Clients described the staff as professional and caring. Clients stated that the staff had made efforts to get to know them and that the staff listened to their individual concerns and responded appropriately.
- Clients using the service said they felt safe and supported. They said they received all of the information they needed and understood what to expect from treatment.

The involvement of clients in the care they receive

- The clients at the service held a community meeting once a week. The meeting allowed the clients to discuss issues that were relevant to them. The service ensured that these meetings were minuted. Minutes of recent meetings showed that clients had raised concerns about various maintenance issues and these had been addressed.
- Clients' views were clearly reflected in their care plans.

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

Access and discharge

- The provider admitted clients from all over the country to the day service. Those requiring treatment were either funded privately or secured funding from a local authority. There was no waiting list for a place at the service. All admissions were planned. Prospective clients could visit the service prior to admission. The service endeavoured to respond to clients who wanted to be admitted urgently. The service did not admit clients at night and operated during office hours and at limited times during the day over the weekend. The service could accommodate up to a maximum of nine clients.
- The service had a clear inclusion and exclusion criteria for people admitted to the service. The service would not admit people who had a history of having seizures as it was deemed too risky. These prospective clients were signposted to a more suitable provider.
- Since the beginning of January 2016, the service had admitted 70 clients. Four clients were receiving treatment at the time of the inspection. Forty-nine clients had successfully completed treatment. Eleven clients had self discharged early. Six clients had been discharged early by PCP. The service did not have targets regarding occupancy and considered each potential new admission on a case by case basis. The average length of treatment was four weeks. However, clients were able to extend their stay for longer subject to funding.
- Due to the average length of stay the service began planning with the clients for discharge as soon as possible. Staff prepared discharge letters for clients when they had completed their stay at the service. This included any action the client needed to take post-discharge such as see their GP or report to the housing office. We saw an example of where the nurse at the service had written separately to a client's GP outlining the treatment they had received while at the service. This was detailed and informative and supported the continuity of the client's care and treatment.
- Four of the seven clients whose records we checked, had specific unplanned discharge plans in place, recording who should be informed and what the client should do if the left the programme early. The other three clients did not. This meant that there was a lack of information readily available for these clients regarding the risks of relapse and who to contact in an emergency.
- The service linked with other providers and the clients' care co-ordinators to support clients with accommodation needs when they completed the programme or left the service.

Substance misuse/detoxification

- Staff helped clients identify recovery meetings they could attend in their local area once they were discharged.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had made efforts to ensure the building promoted the privacy of the clients who were at the service. The building was discretely signposted. The front door and windows of the building had privacy film on them. This meant that members of the public could not see into the building.
- Clients were encouraged to be as independent as possible within the structure of the therapeutic programme. Lunch was provided by the service. Clients were responsible for buying and preparing their own meals. Staff supported clients with budgeting. If clients did not have access to funds to do this, staff liaised with other organisations for example the Department for Work and Pensions (DWP) or local charities that could provide food. Meals other than lunch were provided in the other house provided by PCP (Clapham) Limited. This was registered with CQC as a separate location.
- The service had a range of therapy rooms and a large group room. There was also a comfortable seating area for the clients. Facilities were available so that clients using the service could make hot and cold drinks when they wanted to.
- The premises were light and airy and there was access to a garden at the rear.

Meeting the needs of all clients

- The location of the service was not wheelchair user friendly due to the width of the doors. The service could not admit clients who used wheelchairs. Staff were able to signpost prospective clients to alternative providers if necessary.
- When clients were admitted into the service, staff asked questions regarding the cultural and religious needs of the clients. They used this information to ensure that they provided clients with support that was relevant to their individual needs. For example, they had supported a client to attend a Pride event in London, which caters specifically to the lesbian, gay, bisexual and transgender community.
- The service supported clients who were religious to attend places of worship. A room was available in the service for people who wished to pray.
- All the service literature for both clients and their families was in English. The service did not have any literature in braille or in any other languages. Staff delivered group work and therapy sessions in English. The service said it was able to support individuals in therapy whose first language was not English. However, it was the responsibility of the client or referrer to obtain someone to interpret for them in these circumstances. The service did not provide literature in other languages.
- The service provided the clients with lunch. They were able to provide food to meet the cultural and or religious needs of clients.
- There was a client noticeboard in the service which displayed information about the service, local support groups and information intended to inspire the clients. The service had very little information on display that acknowledged and recognised the diversity of the client group. There was no information in the service for clients who wanted to explore other aspects of their identity or wanted information that was relevant to them. For example, there was no information for clients who maybe lesbian, gay, bisexual or transgender or who had experienced domestic violence or sexual assault.
- Clients commented that whilst they had a number of therapeutic activities available, there was a lack of physical activities to assist them in maintaining their physical fitness.
- The service was non-smoking. If clients wished to smoke, they had to do this in the gardens at the rear of the building. Staff did not offer smoking cessation sessions but supported clients who wished to stop smoking by signposting them to appropriate services.

Listening to and learning from concerns and complaints

- Information on how to complain was readily available to clients. Information regarding the complaints procedure was on display in the location and in the clients' handbook. The service had an informal and formal procedure to deal with complaints and the service encouraged clients to voice their concerns. The staff

tried to resolve complaints as soon as possible. The provider responded to the client within a specified period and we saw evidence of this. If the complainant remained unsatisfied with the provider's response, they were signposted to alternative organisations who could review their complaint.

- The service had received three formal complaints in the 12 months prior to inspection. The provider investigated only one complaint during the specified time frame. The complaint related to quality of treatment that had been offered and the cost. The provider did not uphold this complaint. The other two complaints had similar themes and related to how client information had been handled. There was a delay in investigating and responding to these complaints but the provider upheld the complaint. The Information Commissioner's Office (ICO) reviewed one of the complaints. The ICO reviews complaints made regarding the way an organisation handles personal information. The ICO had contacted the provider regarding the concerns about their information governance. The provider had formulated an action plan as a result of these complaints. The provider had improved some of their processes because of the complaints. Improvements included reviewing their alcohol and opiate detoxification protocols, ensuring that clinical governance meetings were held on a regular basis. The provider had also employed additional staff, which included a dedicated complaints manager and clinical governance manager.

Are substance misuse/detoxification services well-led?

Vision and values

- The provider had a culture statement that set out their vision and values. The service embedded this in the work they undertook with clients. Staff were committed to ensuring that clients were supported to make positive changes in their lives of the provider and the service.
- Staff knew who the senior managers in the organisation were and these managers had visited the service at least quarterly.

Good governance

- The service had a business continuity plan, which was created February 2014 and should be have been reviewed February 2016. The plan dated 2014 detailed what action staff should take should the building became unusable. The provider included information regarding clients continuing to receive their medication, and where the service would be located to. However, it was unclear as to whether this information was still valid because of the lack of review. There was nothing in the business continuity plan that prompted the service to notify the CQC of the incident. This meant that there was a risk that in the case of a significant incident, the appropriate actions may not be taken.
- Following the inspection in May 2015, where requirements were put in place for the service, a number of improvements had been made to the organisational systems. The governance processes for the service were more robust but required further improvement with regards to the monitoring of staff training updates and completion.
- The provider had regular six weekly clinical governance meetings. We reviewed the minutes of the last three clinical governance meetings. The meetings reviewed the activities being undertaken in the service and identified where improvements could be made. For example, there were discussions regarding incidents and what constituted a serious incident, safeguarding, how to improve the appraisal process and ensure that the appraisal completion rate was monitored. The provider had undertaken a number of audits with a view to making improvements at the service. The provider had employed a clinical governance manager and a dedicated complaints manager in response to concerns that had been raised through feedback from the CQC and ICO.
- At the last inspection in May 2015, we identified that there were failures in relation to mandatory training of staff members. During this inspection, we noted there had been improvement. The service had identified a range of training that staff should have to ensure that they were able to provide safe and treatment for clients. The provider had processes to monitor the training completion compliance rate. However, not all staff had completed their mandatory training.

Leadership, morale and staff engagement

Substance misuse/detoxification

- Since the inspection in May 2015, the management at the service had changed. A new service manager had been recruited through internal promotion. This meant that they were familiar with the service. There was now strong leadership at the service, which had led to improvements in the service since the last inspection.
- Staff commented positively regarding their colleagues and stated that they felt motivated and enthusiastic about the work they undertook. Staff told us it that they felt able to suggest improvements. They feel listened to and that their ideas were taken seriously.
- The service was meant to have team meetings at least fortnightly. However, no meetings had taken place between July 2016 and November 2016. Since November, there had been some improvement and meetings were being held at least every fortnight. There was a standard agenda for these meetings which included discussing issues relating to safeguarding, new policies, incidents, complaints and service user feedback.
- There were no ongoing bullying or harassment cases and no staff on long term sickness leave.
- The manager was unclear as to whether the provider had a whistle-blowing procedure, but felt that the confidentiality policy covered matters relating to staff highlighting issues of concern. The manager was confident that all staff knew that they could raise issues either directly with the provider or with the CQC. The staff also stated that they felt they could raise issues.

Outstanding practice and areas for improvement

Outstanding practice

- The service was not participating in any research and were focusing on improving the service.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

- The provider must ensure that infection control risk assessment of the service is robust and correctly identifies areas within the service that present a risk of infection. The provider must ensure that the clinic room is kept clean.
- The provider must ensure that they clean the physical health monitoring equipment and maintain records of frequency of cleaning.
- The provider must ensure that checks on staff are carried out before they start working in the service. The provider must ensure that they have a DBS for the doctors that work in the service and that they have appropriate qualifications and have been revalidated.
- The provider should must ensure that all high risk clients have an early exit plan in place.
- The provider must ensure that they have systems to assess the risks posed to children or adults at risk when they are undertaking assessments

Action the provider SHOULD take to improve

- The provider should ensure that they undertake environmental checks on a regular basis. The provider should ensure that they continue to calibrate the physical health monitoring equipment on a regular basis. The provider should ensure that infection prevention and control audits are carried out and recorded to enable staff to learn from the results and make improvements to the service. The provider should ensure that they make improvements in line with the findings from their audits. The provider should ensure that they have processes in place to ensure that audits are undertaken on a regular basis
- The provider should ensure that staff and clients have means to summon assistance from staff require it.
- The provider should ensure that staff complete their mandatory training to ensure that staff are supported to carry out their roles safely and effectively.
- The provider should consider how they support clients whose first language is not english.
- The provider should ensure that observations of staff practice and competence are recorded, dated and signed.
- The provider should ensure that their Business Continuity Plan is updated. The plan should provide details as to who the provider should contact in the event of an incident.
- The provider should ensure that the handwritten notes in the clients' files can be easily read by all staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
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 did not ensure that there was an effective process in place to prevent, detect and control the spread and risk of infections. There were no cleaning records for the medical equipment that was being used in the service. The clinic room was not clean. The provider had not ensured that all clients had a comprehensive early unplanned exit plan. The provider had not ensured that the doctors working in the service had the relevant qualifications and training to work with the client group. This was a breach of regulation 12 (1) (2)(a)(b)(c)(e)(h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Staff did not have all of the pre-employment checks required in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment procedures were not effective. The provider had not ensured that the doctors were of good character. They had not obtained a Disclosure and Barring check for the doctors contracted to work at the service

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust procedures to assess the risks relating to the health, safety and welfare of children or adults at risk. This was a breach of regulation 17 (2)(b)

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.