# PCP (Clapham) Limited PCP Leicester

## Quality Report

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

## Ratings

### Overall rating for this location

| | |
|---|---|
| Are services safe? | |
| Are services effective? | |
| Are services caring? | |
| Are services responsive? | |
| Are services well-led? | |

### 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.

# Summary of findings

## Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Overarching governance of the service was not embedded practice. Management did not monitor new guidance and policy to ensure it was effective. Management did not evaluate and check their quality improvements for effectiveness. The service did not have targets or key performance indicators. Quality assurance management and performance frameworks were not in place. The risk register was incomplete. Registered managers did not have sufficient time, authority or autonomy to carry out their duties effectively. Communication between senior management and location managers and staff was not always good. Not all recruitment processes were robust. The provider did not have clear vision and values.
- Poor cleanliness due to lack of monitoring in the communal kitchen area posed a risk of infection for staff and clients. Managers had not included blind spots on the environmental risk assessment.
- Management had not completed clinical audits. There were no external audits of the processes relating to medicines management and dispensing medication for the three months prior to inspection. The medications policy did not reflect amendments to the health and social care regulations or current guidance around medication management. There was no controlled drugs accountable officer for the service, and in the absence of a drugs accountable officer the provider had not addressed the need to work in partnership with a local pharmacist, or the local controlled drugs accountable officer group.
- Following a medication error management had, considered this to be due to human error and not made any changes to practice. However, they had not considered what changes would reduce the chances of the human error occurring in the future.
- We expressed concern about the providers practice of accepting new referrals on a Friday morning for detoxification over the weekend, when there were no clinical staff on site.
- Three clients and two family members we spoke with were not happy that staff had not invited them to view the accommodation prior to admission or signing their treatment agreement.

However, we also found the following areas of good practice:

- The treatment centre had enough staff to provide safe treatment. Staff and doctors had completed comprehensive risk assessments for all clients. Risk assessments included processes to follow for a client who unexpectedly exits treatment. The service rarely cancelled appointments or groups due staff shortages or sickness.
- Staff and doctors completed full mental health and physical health assessments for all clients. Treatment plans were holistic, personalised, and identified client's strengths and existing coping strategies. Care plans and risk management plans reflected the diverse and complex needs of clients including clear care pathways to other supporting services and support for clients with the transition back to community living.
- Doctors followed good practice in managing and reviewing medicines including following British National Formulary recommendations. The service had embedded relevant National Institute for Health and Care Excellence guidelines. Staff used recognised treatment outcome measures, therapy and support staff had attended specialist training.
- Clients told us access to the service was easy and efficient. The opportunities for their families to be involved and supported during their treatment and the aftercare offered by PCP Leicester were some of the best they had encountered. Furthermore, we saw 21 feedback forms 17 of which praised the staff and the treatment programs offered.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Substance misuse/ detoxification** | | No rating given as we do not rate substance misuse services |

# Summary of findings

## Contents

# PCP (Clapham) Limited PCP Leicester

**Services we looked at**
Substance misuse/detoxification

# Summary of this inspection

## Background to PCP (Clapham) Limited PCP Leicester

PCP Leicester registered with the Care Quality Commission in December 2014 and is a residential psychosocial drug and alcohol, medically monitored detoxification and rehabilitation facility. It is based in Leicester city centre, Leicestershire. At the time of inspection, the service had a registered manager John Wilson, and a nominated individual. They did not have a controlled drugs accountable officer.

The service includes a treatment centre where clients attend for daily therapy sessions, and a seven-bedded detoxification house, known as St Stephens for people undergoing detoxification with 24-hour supervision. A further 8 bedded house, known as Wordsworth House was available for clients in the secondary treatment phase of the treatment program. St Stephens is separately registered with the care quality commission, and although inspected alongside PCP Leicester it has been reported on separately. Wordsworth House is not required to be registered with the Care Quality Commission, and therefore was not inspected.

PCP Leicester provides ongoing abstinence based treatment, which focuses on the 12- step programme and integrates cognitive behavioural therapy, motivational interviewing, integrated psychotherapy, psycho-social education and solution focussed therapy.

PCP Leicester is registered with CQC to provide treatment of disease, disorder or injury.

At the time of inspection, eleven people were accessing the service for day treatment. The length of stay for clients in treatment was between two and twelve weeks. A further twelve people were in secondary treatment, some of whom were living at Wordsworth House.

The service provides care and treatment for male and female clients. PCP Leicester accepts self-referrals from privately funded individuals and drug and alcohol community teams primarily from around the midlands area.

The Care Quality Commission has carried out two inspections in November 2015 and March 2017. Following the last inspection, we found the following practices needing action by the provider:

- The provider must ensure they have access to specialist medical cover during evenings and weekends.
- The provider must ensure that a lone worker policy is in place specifically for this service.
- The provider must ensure staff can summon help in an emergency when meeting with clients in interview rooms.
- The provider must ensure the ligature audit is fully complete, and fit for purpose.
- The provider must ensure the fridge temperature is monitored and maintained, and that food is stored in line with guidance.
- The provider must ensure they maintain complete and proper records of all fire drills carried out.
- The provider must ensure an official first aider is appointed and appropriate signage relating to access for the first aider is displayed in the therapy unit.
- The provider must ensure all medical equipment is calibrated and full calibration records are maintained.
- The provider must ensure all incidents that require reporting to CQC, as per the reporting guidance, are reported using official CQC processes.
- During the current inspection we noted the following improvements: up to April 2018 the provider had included a clinical nurse lead on their out of hours on call roster. Managers had reviewed the lone worker policy to ensure at least two staff on duty always. All staff carried personal alarms when on duty. Staff had created the ligature audit in 2017 and reviewed it in June 2018. Staff checked food fridges and all staff had completed food hygiene training, and clients received advice about safe food storage as part of their induction to St Stephens. Managers had appointed and trained first aiders and fire

# Summary of this inspection

marshals, and staff recorded fire drills. Staff checked all medical equipment and ensured calibration was in date. Managers reported incidents to CQC promptly.

## Our inspection team

The team that inspected the service comprised CQC inspector Debra Greaves (inspection lead), two other CQC inspectors, and a specialist advisor nurse with expertise in substance misuse.

## Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England met the Health and Social Care Act 2008 (regulated activities) regulations 2014.

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, and asked other organisations for information

During the inspection visit, the inspection team:

- visited the treatment centre for this location, looked at the quality of the physical environment, and saw how staff were caring for clients
- spoke with ten clients and three family members
- spoke with the registered manager and the health and safety advisor
- spoke with four other staff members employed by the service provider, including nurses and volunteer support workers
- received feedback about the service from one external organisation
- attended an aftercare support group
- collected feedback using comment cards from four clients and a further 21 client feedback forms
- looked at 10 care and treatment records, including medicines records, for clients
- reviewed eight staff files
- observed administration of medicines
- 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 ten clients, collected feedback from four clients comment cards and looked at 21 feedback forms completed by clients at the time of discharge.
- Clients told us staff were interested in their wellbeing, were respectful, polite, and compassionate. They said they felt safe while using the service, and were happy with the treatment they received for physical and mental health, as well as support for their substance misuse. Clients said they were involved in their treatment plan and their exit plans.
- Clients said access to the service was easy and efficient. The opportunities for their families to be involved and supported during their treatment, and the aftercare offered by PCP Leicester were some of the best they had encountered.
- Families could be involved in treatment with client agreement. The service facilitated monthly family meetings. Staff asked family members for feedback about care and treatment.

However:

- Three clients and two family members were not happy that staff had not invited them to view the accommodation prior to admission. Two clients said that if they had visited before signing their agreements they would not have accepted their places at PCP Leicester.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needed to improve:

- Poor cleanliness due to lack of monitoring in the communal kitchen area posed risk of infection for staff and clients. There were dirty cups and plates left around the sink area, staff had not cleaned the inside of the fridge. Staff had not cleaned the corners of the floor in the kitchen, there was a dirty mop and bucket left in the food preparation area, and staff informed us they only had one mop for all spillage tasks around the centre.
- We did not see any independent external audit of the processes relating to medicines management and dispensing medication, and no clinical lead audits for the three months prior to inspection. The agency nurse was unsure what the external processes were for carrying out this auditing. Staff had not reviewed the medications policy to reflect amendments to the health and social care regulations or current guidance around medication management. There was no controlled drugs accountable officer for the service, and no other provision to cover the duties of this role. The service did not work in partnership with a community pharmacist to complete pharmacy audits, check client's prescriptions, and externally scrutinise the auditing processes.
- Blind spots were not included on the environmental risk assessment.
- There had been a medication error, which managers considered to be due to human error, rather than failure of policy or procedure. However, they had not considered what changes they could make to reduce the chances of the human error occurring in the future.
- We expressed concern about the practice of accepting new referrals on a Friday morning for detoxification. Guidance suggests the first 24 hours for people undergoing detoxification carry high risk. Given the providers current arrangements for medical availability there would be no medical staff available until the following Tuesday morning.

However, we also found the following areas of good practice:

- The treatment centre had enough staff to provide safe treatment during the working day including drug and alcohol

# Summary of this inspection

counsellors, a manager who was also a qualified drug and alcohol counsellor, an administrator, peer supporters, volunteer counsellors, a nurse, and visiting doctors. The average case load was three clients to one counsellor.
- 100% of staff had completed induction, which included how to raise safety concerns and report incidents, 90% of staff had completed mandatory training, including medication management, safeguarding vulnerable people, and conflict management.
- Staff and doctors had completed an initial risk assessment for all clients. Staff ensured they were comprehensive and included processes to follow for a client who unexpectedly exits treatment.

## Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff and doctors completed full mental health and physical health assessments for all clients on the day of admission. Treatment plans were holistic, personalised, and identified client's strengths and existing coping strategies. Care plans included care pathways and interventions to support clients with the transition back to community living.
- Doctors prescribed medication regimes to support the first few days of the detoxification programme. Doctors followed good practice in managing and reviewing medicines including following British National Formulary recommendations. The service had embedded relevant National Institute for Health and Care Excellence guidelines. Staff were familiar with the Department of Health guidance: Drug misuse and dependence: UK guidelines on clinical management (2007) for alcohol and opiate detox, known as the "orange book". An alcohol and opioid detox protocol was in place, which followed national guidance. Staff used recognised treatment outcome measures to monitor change and progress in key areas of the lives of people treated within the service.
- The service had clear admission and discharge policies and there was no waiting list for new admissions. Staff supported clients to formulate their own leaving plans, including unexpected exit from treatment. The service offered follow on support for clients who had completed their treatment programme.

However we also found the following areas the service provider needed to improve:

# Summary of this inspection

- Staff believed that for the six weeks prior to inspection there was no out of hours medical or specialist clinical cover for the service. Senior managers explained that this was a mis-communication and, in the event, staff followed the out of hours emergency access procedures.

## Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Staff showed understanding about the impact their treatments had on clients emotional and social wellbeing. Staff showed awareness of clients' individual needs and preferences and discussed these during the handover. When talking to us about client care staff were mindful of keeping client confidentiality.
- Staff and clients, had reviewed goals together throughout treatment. Staff o. Clients had a named key worker and clients knew who their key worker was. All clients in treatment received weekly one-to-one sessions with their named keyworker.
- Clients said they felt safe while using the service, and were happy with the treatment they received for physical and mental health, as well as support for their substance misuse. Clients said they were involved in their treatment plan and their exit plans.
- Clients told us access to the service was easy and efficient. The opportunities for their families to be involved and supported during their treatment, and the aftercare offered by PCP Leicester were some of the best they had encountered.

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

- Three clients and two family members were not happy that staff had not invited them to view the accommodation prior to admission. Two clients said that if they had visited before signing their agreements they would not have accepted their places at PCP Leicester.

## Are services responsive?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients reported access to the service through the admission process had been easy, quick, and efficient. There was no

waiting list for PCP Leicester, and no delayed discharges. Doctors admitted new clients when medical staff were on the unit. The service did not accept urgent referrals or admit clients during the night.
- The service rarely cancelled appointments or groups due staff shortages or sickness Staff worked with clients to prevent them from disengaging in their treatment.
- There were a range of rooms available, including group rooms, individual therapy rooms, a clinic room, seating areas for lunch and a relaxation lounge. Clients had access to a smoking area at the treatment centre.
- Care plans and risk management plans reflected the diverse and complex needs of clients including clear care pathways to other supporting services e.g. maternity, social, housing or community mental health teams.

## Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needed to improve:

- Overarching governance of the service was not embedded practice. While the external cleaning company were completing checklists for cleaning and maintenance, staff were not checking the completed work as part of audit. Management had developed new policies and guidance but they had not implemented all of it promptly, such as the lone worker policy. Managers were not monitoring new guidance and policy to ensure it was working. While senior management felt they were working towards quality improvement, they were not evaluating and checking the quality improvements for effectiveness.
- The service did not have targets or key performance indicators. Registered managers did not have enough authority or autonomy to carry out their roles effectively. Recruitment processes were not robust. While the recruitment processes were adequate for therapy staff, for other staff they were not so rigorous.
- The provider had not addressed the need to work in partnership with a local pharmacist, the local controlled drugs accountable officer group or appoint a controlled drugs accountable officer. Staff had not reviewed medications policies, to reflect changes in regulation and guidance. Staff had not completed clinical audits.
- The risk register was incomplete. Managers had not recorded the risks associated with not having a substantive nurse.

# Summary of this inspection

Communication between senior management and location managers and staff was not good and mis-communications had potentially serious consequences. The provider did not have documented vision and values, and managers said this was a work in progress.

However, we also found the following areas of good practice:

- Staff morale at the service was good. Staff told us they felt valued and rewarded for the job they did. We saw positive interactions between staff members. Between November 2017 and June 2018 there were no unauthorised absences/ or sickness days taken by staff.
- Therapy staff provided leadership within the service. Staff felt the leadership of the service encouraged an open, supportive and honest culture.
- The provider had been willing to take feedback on board from previous inspections and a registration visit, and made changes accordingly.

# Detailed findings from this inspection

## Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a policy relating to the Mental Capacity Act. Staff could not recall the last time a client had impaired capacity but understood the principles of best interest meetings and the need to support clients to be as involved as possible in any decisions made on their behalf.
- Staff discussed and checked capacity with all clients on admission, and monitored any changes through daily interactions.
- 90% of staff had completed training in the Mental Capacity Act 2005. Staff had knowledge of the five statutory principles of the Act, including capacity and the impact it could have on clients they were working with.

# Substance misuse/detoxification

| | |
|---|---|
| Safe | |
| Effective | |
| Caring | |
| Responsive | |
| Well-led | |

## Are substance misuse/detoxification services safe?

**Safe and clean environment**

- Poor cleanliness due to lack of monitoring in the communal kitchen area posed a risk of infection for staff and clients. There were dirty cups and plates left around the sink area, staff had not cleaned the inside of the fridge. Staff had not cleaned the corners of the floor in the kitchen, there was a dirty mop and bucket left in the food preparation area, and staff informed us they only had one mop for all spillage tasks around the centre. There was a cleaning contract for nine hours per week at the treatment centre, and managers had appointed a part time health and safety advisor.
- Staff maintained equipment, there was evidence of portable appliance safety testing on all electronic equipment throughout the treatment centre. We saw a checklist of electrical equipment signed and dated by an electrician, showing completion of safety testing.
- While staff had completed environmental risk assessments, that included ligature risks and had identified actions to remove, reduce or mitigate the risks, they had not included blind spots on the assessments. All staff carried working personal alarms in case of emergency. Managers had appointed first aiders and a fire marshal, staff had recorded fire alarm tests and two full fire drills.
- The service had a well-equipped clinic room with the necessary equipment to carry out physical examinations. We saw completed records to show they had calibrated all necessary equipment. Staff regularly checked the temperature of the medication fridge and adjusted the temperature according to the storage requirements for the medications. Staff had access to emergency equipment including a defibrillator and naloxone (used to reverse the effects of opioids). Managers ensured that staff knew how to use the equipment. A clinical waste disposal contract was in place to collect and dispose of clinical waste

**Safe staffing**

- PCP Leicester consisted of three drug and alcohol counsellors, a manager who was also a qualified drug and alcohol counsellor, an administrator, a part time health and safety advisor, one peer supporter, and three volunteer counsellors. At the time of inspection, the nurse post was vacant and filled with a regular agency staff member.
- Managers estimated the number of staff needed based on client need and the therapy programmes in place at any given time. The average caseload was three clients per counsellor. Managers ensured all clients had a named counsellor as their key worker.
- All therapy staff, including volunteers, had in date disclosure and barring service certificates and where necessary managers had carried out staff risk assessments.
- Except for the vacant nurse post, managers covered staff absences within the team. Between May 2017 and June 2018 there were no unauthorised absences/ and four sickness days taken by staff.
- 90% of staff had completed an induction, which included how to raise safety concerns and report incidents. 90% of staff had completed mandatory training in health and safety awareness and care specific topics such as care planning, medication, records keeping, consent, Mental Capacity Act, conflict management, breakaway techniques and safeguarding of vulnerable adults.

# Substance misuse/detoxification

- The service had access to one of two doctors for three hours a day, three mornings per week (Tuesday, Wednesday, and Friday). The two doctors provided cover for each other's absence according to their contracted hours. However, the doctors told us that while they would try and respond to staffs' requests outside of their contracted hours and during office hours, they could not guarantee being able to do this, and they were not available for emergencies during evenings and weekends. Doctors told us if staff needed urgent medical advice or support outside of their contracted hours staff either contacted the clients GP, or took the client to a walk-in centre or the accident and emergency department.

**Assessing and managing risk to clients and staff**

- We reviewed ten care records. Staff had completed an initial risk assessment for all clients. Staff ensured they were comprehensive and included processes to follow for a client who unexpectedly exits treatment. Staff made clients aware of the risks of continued substance misuse and harm minimisation as part of the discharge planning process. Staff had updated all risk assessments within the past month.
- Staff told us if they noticed deterioration in a client's physical health, they referred them to the walk-in centre, the local GP or seek guidance from the doctor, if available or nurse on the unit. Staff monitored early warning signs of mental or physical health deterioration during daily contact with clients.
- The doctor reviewed all clients' medication on admission, introduced detoxification medication, and reviewed medication periodically during the clients stay at the service. We saw comprehensive doctors' assessments including risk assessments based on a self-assessment proforma, clients previous risk management plans, GP records and face-to-face consultation with the prospective client prior to admission.
- In the absence of a permanent nurse and to ensure that clients risks were assessed properly, the doctor had found it necessary to amend the pre-admission risk assessment process. The doctor had started seeing all new clients and carrying out his own face to face risk assessment before agreeing admission for treatment.
- We expressed concern with management about the practice of accepting new referrals on a Friday morning for detoxification. Guidance suggests the first 24 hours for people undergoing detoxification carry high risk. Given the providers current arrangements for medical availability there would be no medical staff available until the following Tuesday morning, and no clinical staff on duty until the Monday morning. This could put clients at extra risk of harm or injury should they develop complications between 5.00pm on a Friday and 9.00am on a Tuesday.
- 90% of staff had trained in safeguarding vulnerable adults and children. Staff we spoke with knew when and how to make a safeguarding referral. The service had both a child protection policy, and a policy covering children visiting family members at the service. Staff had displayed safeguarding information in the office and foyer.
- All staff had trained in de-escalation, conflict management and medicines management, there were always two members of staff present when administering controlled drugs.
- We did not see any independent external audit of the processes relating medicines management, and dispensing medication, and there had not been any clinical nurse lead audits for the three months prior to inspection. The agency nurse was unsure what the external processes were for carrying out this auditing.
- The medications policy did not reflect amendments to the health and social care regulations or current guidance around medication management. There was no controlled drugs accountable officer for the service. The service did not work in partnership with a community pharmacist to complete pharmacy audits or to check client's prescriptions. External scrutiny of the auditing processes was not in place. However, we saw the manager and nurse had completed internal weekly and monthly controlled drug audits, and the nurse had completed the controlled drugs destruction book and a returned drugs book.
- The service held a Home Office stock license. This meant that when presented with an alcohol dependent person in severe withdrawal the nurse could administer medication from stock under the doctors' instruction to reduce risk of alcohol withdrawal related

complications. The doctor completed a stock medication instruction and medication card for all clients needing detoxification and an up to date medications administration chart was available for each client.

- While managers had revised the lone worker policy for the service dated August 2017, management had only recently (eight days prior to inspection) implemented it to include at least two staff present in the house or at the centre at all times.
- Although managers had revised the out of hours on call processes and emergency contact telephone numbers to ensure a senior manager would respond to all urgent out of hours calls promptly, staff did not think there had been any specialised medical or clinical out of hours advice available for the six weeks prior to inspection. Staff believed the person providing this service had left the organisation. Senior managers denied this stating it had been a mis-communication between the senior management team and staff at PCP Leicester. The impact was that staff accessed accident and emergency services as first step, rather than internal support and advice.
- Staff kept client files in locked cabinets within their offices which were only accessible to staff. The service used paper and electronic recording systems. When it was necessary to transport essential client notes between the therapy unit and the accommodation house, staff used a secure case for this purpose

**Track record on safety**

- The service had reported three incidents in the twelve months prior to inspection. Two incidents related to clients who had needed to attend the accident and emergency department before discharge back to the centre, and one involved a medication error.

**Reporting incidents and learning from when things go wrong**

- The service had an incident and accident reporting policy, staff knew what an incident was and how to report it to their managers. Staff had reported all incidents that needed reporting to CQC.
- Senior management discussed incidents at their monthly clinical governance meetings, and we saw some evidence of managers carrying out change in response to those discussions. However, we had concerns that after one serious incident senior managers had not made any changes to policy or procedure following a medication error. While managers considered this to be due to human error, rather than failure of policy or procedure, they had not considered what changes would reduce the chances of the human error occurring in the future.
- Staff received feedback from incidents during daily handovers and bi-weekly team meetings. Team meeting minutes showed feedback from incidents. Staff confirmed they had received debrief and supervision following any serious incidents.

**Duty of candour**

- Managers and staff were aware of the Duty of candour. There was an up to date Duty of Candour policy. Managers encouraged staff to be candid with clients, and minutes of meetings showed when staff had been open and honest with clients.

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

**Assessment of needs and planning of care**

- We looked at 10 client case files. Staff had completed full assessments for all clients on the day of admission. Client's case files held all pre-admission assessments and information.
- The doctor completed medical and risk assessments at the point of admission for treatment; these included a physical health examination to ensure suitability for the detoxification programme. If in the opinion of the doctor people were not suitable for the service the doctor advised where they could get further help if they wanted it.
- Staff carried out physical health checks including blood pressure, breathalysing, and urine testing. Doctors prescribed medication regimes to support the first few days of the detoxification programme. Staff were aware of the signs and symptoms of detoxification complications and knew how to access emergency help when needed.

# Substance misuse/detoxification

- Staff updated individual treatment plans weekly. All treatment plans we reviewed were holistic, personalised, and identified client's strengths and existing coping strategies. Staff discussed and recorded client's goals throughout treatment and upon discharge.
- Care plans included care pathways and interventions to support clients with the transition back to community living. Pathways included supporting abstinence from drug and alcohol usage, and helping them to access alcoholics anonymous and narcotics anonymous groups in their local areas.
- Staff offered clients healthy lifestyle advice and choices as part of their ongoing care planning.

**Best practice in treatment and care**

- We looked at 10 client care records and all records showed good practice in the areas reported below.
- Doctors followed good practice in managing and reviewing medicines including following British National Formulary recommendations.
- Staff were familiar with the Department of Health guidance: Drug misuse and dependence: UK guidelines on clinical management (2007) for alcohol and opiate detox, known as the "orange book". An alcohol and opioid detox protocol was in place, which followed national guidance.
- The service had embedded relevant National Institute for Health and Care Excellence guidelines. The service offered daily activities and therapies based on the 12-step model for drug and alcohol abstinence and cognitive behavioural therapy. Other therapies included, structured group work, self-esteem workshops, goals workshops, anger management workshops, one to one key working and access to mutual aid groups.
- Staff used the Treatment Outcomes Profile to measure change and progress in key areas of the lives of people treated within the service. These measures included the Severity of alcohol dependence questionnaire (SADQ), (), which rates common signs and symptoms of opiate withdrawal used to monitor symptoms. Staff also used The Clinical Institute Withdrawal Assessment for Alcohol, (-Ar), a ten-item scale used in the assessment and management of alcohol withdrawal.
- Staff referred clients to the local walk in centre when there was a general health care need. Staff temporarily registered all clients accessing treatment for longer than 28 days, or who had a pre-existing health condition, with the local GP surgery for any healthcare needs.
- Staff supported clients to attend a sexual health or genitourinary medicine clinic for blood borne virus testing and vaccination and advice or treatment for sexual health if needed.
- Staff routinely conducted health screening as part of clients care and treatment. This included titration of medication and physical observation to help inform the client's treatment and detoxification regimes.

**Skilled staff to deliver care**

- The multi-disciplinary team consisted of counsellors, a qualified nurse, a part time health and safety advisor, an administrator, a registered manager, a volunteer peer mentor and three volunteer counsellors.
- Therapy staff, were always available during the working day when needed for support.
- At the time of inspection there was no out of hours medical or specialist clinical cover for the service. The clinical nurse lead who normally provided this cover had been taken off the out of hours on call roster.
- All staff, apart from one, had received induction to the service. Induction included raising staffs' awareness to all the necessary skills and knowledge they needed to work with the client group. Volunteers underwent the same induction and mandatory training as permanent staff. There was one staff member who had not had full induction, supervision or specialist training for their work role.
- Both doctors had revalidated in the previous 12 months.
- Staff had access to specialist training for their role. 100% of eligible staff had completed (Haringey Advisory Group on Alcohol) HAGA: alcohol dependence, withdrawal and detoxification; (Royal College of General Practitioners) RCGP management of alcohol problems in primary care; RCGP alcohol brief identification and advice; RCGP management of drug misuse, and (Royal Pharmaceutical Society) RPS accredited medication training,

# Substance misuse/detoxification

- There had been no concerns with poor staff performance within the last year. Managers told us that if they had any concerns they held both informal and formal meetings to discuss the concerns.

**Multidisciplinary and inter-agency team work**

- Staff had access to fortnightly team meetings. Staff kept minutes of these meetings in a file in the staff office.
- Staff attended handovers twice daily. These meetings included discussion around any client issues or risks, the timetable for the day, incidents, and detox updates.
- Staff told us they had good links with local GP surgeries, police and probabtion and PCP's move on housing scheme. Staff reported that because many of the clients were from outside the Leicester catchment area links with community mental health teams and key workers in the community substance misuse services were on an as and when basis.

**Adherence to the MHA**

- The Mental Health Act was not applicable to this service; clients using the service were not detained.

**Good practice in applying the MCA**

- Staff discussed and checked capacity with all clients on admission, and monitored any changes through daily interactions.
- 90% of staff had completed training in the Mental Capacity Act 2005. Staff had knowledge of the five statutory principles of the Act, including capacity and the impact it could have on clients they were working with.
- There was a policy relating to the Mental Capacity Act. Staff could not recall the last time a client had impaired capacity but understood the principles of best interest meetings and the need to support clients to be as involved as possible in any decisions made on their behalf.

**Equality and human rights**

- The service had policies relating to equality and diversity, mandatory training included awareness of equality and diversity, and staff knew how to access the policies when needed. Staff were aware of the need to not infringe client's human rights.

**Management of transition arrangements, referral and discharge**

- The service had clear admission and discharge policies. Staff carried out comprehensive assessment on admission. When staff discharged clients on new medication regimes or with new physical health conditions the doctor ensured that the clients general practitioner was aware of the new information.
- The service did not have a waiting list for new admissions. Staff accepted referrals from community drug and alcohol teams and on a private basis for clients.
- While clients could visit the centre before accepting a place, staff did not tell them that the accommodation was in a separate building some 10 minutes' walk from the centre.
- Staff supported clients to formulate their own leaving plans, including unexpected exit from treatment, as part of the treatment programme. Staff gave clients information on accessing local support groups on discharge.
- The service offered follow on support for clients who had completed their treatment programme. Clients, who had completed their treatment plans could access the weekly after care group, and family members had opportunity to attend monthly support group meetings. Where appropriate, clients could take up the opportunity to live in PCP supported housing and continue to attend the service for support, or they could apply to become a volunteer at the service.

## Are substance misuse/detoxification services caring?

**Kindness, dignity, respect and support**

- We saw staff interacting with clients in a kind, considerate and caring manner. Clients reported that staff were interested in their wellbeing, respectful, polite and compassionate. Staff showed understanding about the impact their treatments had on clients emotional and social wellbeing.
- Staff knew clients on a first name basis and could discuss clients in depth. Staff had an awareness of

clients' individual needs and preferences and discussed these during the handover. When talking to us about client care staff were mindful of keeping client confidentiality.

- Staff felt able to raise concerns about disrespectful, discriminatory or abusive behaviour and attitudes and knew how to do so.

**The involvement of clients in the care they receive**

- Clients received a welcome pack on admission. The welcome pack included a treatment contract, compliments, complaints and suggestions forms, advocacy information, common questions and answers and advice around local GP and dental services.
- Clients said they were involved in, and offered, a copy of their treatment plan. Client files showed how staff and clients had reviewed their goals together throughout treatment. Staff offered interventions aimed at supporting and improving the clients' social networks and gave support for people to attend community resources.
- Families could be involved in treatment with client agreement. The service facilitated monthly family meetings.
- Clients had a named key worker and clients knew who their key worker was. All clients in treatment received weekly one-to-one sessions with their named keyworker.
- Client files held a confidentiality and information sharing agreement, along with a signed copy of their PCP contract, treatment agreement and a detoxification agreement if needed.
- Clients could give feedback on the service during weekly community meetings or on the feedback form given to each client upon discharge.
- We looked at 21 feedback records for discharged clients, of the comments there were nine negative comments relating to poor cleanliness at the accommodation, and 17 positive comments relating to the structure and effectiveness of the therapy program.

## Are substance misuse/detoxification services responsive to people's needs?

(for example, to feedback?)

**Access and discharge**

- Clients reported access to the service through the admission process had been very easy, quick and efficient. There was no waiting list for PCP Leicester, and no delayed discharges. Doctors admitted new clients when medical staff were on the unit. The service did not accept very urgent referrals or admit clients during the night.
- The service had a documented acceptance and referral criteria agreed with relevant services and key stakeholders, and a clear admission process with target times from referral to triage to comprehensive assessment and from assessment to treatment/care. Clients could access specialist services, support and urgent care when needed.
- PCP Leicester accepted referrals from private individuals and referral agencies. Data for the period May 2017 to June 2018 provided at the time of inspection, showed that PCP Leicester had received 106 referrals. Ninety-five of the referrals were accepted and nine screened out as not suitable for this service. Of the ninety five accepted referrals, 86 people accepted a place and nine people declined a place. Of the 86 admissions 60 clients completed treatment and discharged, while 26 clients had dropped out or discharged before treatment had completed. The provider said they had a 70% success rate overall. At the time of inspection there were 10 clients in active treatment. Six of these were residential and four in second stage step down treatment. The provider did not know how many of the referrals had been re-presentations.
- Staff completed a pre-admission assessment with clients to assess suitability prior to offering them a place in treatment. Exclusion criteria included clients who had previously experienced seizures during detox and recent self-harm or suicide history. The registered manager or nurse and doctor assessed all referrals on a case-by-case basis. Staff signposted any referrals not accepted by PCP Leicester to other more appropriate services.
- Clients formulated their own leaving plans and discussed these plans during therapy sessions.

# Substance misuse/detoxification

- The service rarely cancelled appointments or groups due staff shortages or sickness. Clients we spoke with said they had not experienced any cancelled sessions or activities. Staff worked with clients to include them in their care and prevent them from disengaging in their treatment.

**The facilities promote recovery, comfort, dignity and confidentiality**

- There were a range of rooms available, including group rooms, individual therapy rooms, a clinic room, seating areas for lunch and a relaxation lounge. Clients who were on detoxification programs had the opportunity to use a quiet room if they felt unwell and could not engage in treatment.
- Facilities were available for clients to make a hot or cold drink when they wanted to. Staff ordered sandwiches for delivery from a local café for lunch. Clients could choose from a range of sandwiches but clients said the choice was limited and boring considering what the café could offer. Clients were self-catering for breakfast and evening meal and catered to their own individual dietary needs.
- Clients had access to fresh air while at the treatment centre. Clients were encouraged to follow smoking cessation plans. We saw comfortable dining areas with adequate seating at the treatment centre.

**Meeting the needs of all clients**

- Clients confirmed they could meet their spiritual needs while they were in treatment. Staff showed understanding of the potential issues facing vulnerable groups e.g. Lesbian, Gay, Bisexual and Transgender, Black and Minority Ethnicity, older people, people experiencing domestic abuse and offered support.
- Although information in other languages was not readily available the service was able to supply leaflets in languages other than English on request. While staff provided British sign language interpreters as needed, clients had to pay for other language interpreters. Staff explained this to clients as part of the admission process.
- Care plans and risk management plans reflected the diverse and complex needs of clients including clear care pathways to other supporting services e.g. maternity, social, housing or community mental health services.
- The service was not able to accommodate disabled people. While the service could adjust for people in response to meet needs, such as spiritual, and cultural needs, the building location and design, presented access restrictions. Management advised that they could accommodate disabled people at one of their other locations, and as most clients preferred to attend a therapy out of their catchment area this did not cause clients any problems.

**Listening to and learning from concerns and complaints**

- The service had complaints processes. The service had received six complaints in the 12 months prior to inspection, staff upheld one of the complaints but not the remaining five, no complaints had been referred to the ombudsman. Managers explained that they dealt with verbal complaints and comments on feedback forms at local level, and senior managers dealt with written formal complaints at organisational level. Two clients we spoke had made verbal complaints about the service, one felt they had received an adequate response but no action and the other had been disappointed with the response and was considering making a formal complaint.
- The service received 32 compliments in the 12 months prior to inspection, most of which were on feedback forms given by clients at the end of treatment, others were on thank your cards displayed in the reception area of the centre.
- Clients knew how to complain. Clients welcome packs included information about the providers complaints procedure. Staff knew how to handle complaints appropriately.

## Are substance misuse/detoxification services well-led?

**Vision and values**

# Substance misuse/detoxification

- The provider did not have documented vision and values, and managers said this was a work in progress. However, staff we spoke with described the values of the service as empowerment and mutual respect being at the heart of all the work they did. The service had a clear definition of recovery that staff understood. In the absence of formal vision and values it was difficult to decide if team objectives were consistent with those of the organisation.
- Staff said while they knew who the most senior managers were, they had also been aware of a lot of changes in the senior staff team but communication from senior management about the changes had not been effective.

**Good governance**

- Overarching governance of the service was not embedded practice. While staff were completing checklists for cleaning and maintenance, managers were not checking the completed work. Management had developed new policy and guidance but they had not implemented all of it promptly, such as the lone worker policy. Managers were not monitoring new guidance and policy to ensure it was working.
- Recruitment processes were not robust. While the recruitment processes were adequate for therapy staff, for other staff they were not so rigorous. Managers had appointed some staff who did not have relevant expertise, qualifications or knowledge, and managers had not put in place training plans, or time and support to help the post holders gain these skills and knowledge.
- Staff had not completed clinical audits. The provider had not addressed the need to work in partnership with a local pharmacist, the local controlled drugs accountable officer group or appoint a controlled drugs accountable officer. Staff had not reviewed medications policies, neither had they updated the policies to reflect changes in regulation and guidance.
- The service did not have targets or key performance indicators. The registered manager did not have enough time, authority or autonomy to carry out their roles effectively. Q
- The risk register was incomplete. Managers had not recorded the risks associated with not having a substantive nurse. However, staff did know how to report hazards and risks to the managers.
- 90% of staff had completed mandatory training. Mandatory training included safeguarding children and adults, lone working, safeguarding vulnerable adults, Mental Capacity and detoxification and medication specific training.
- We reviewed eight staff and volunteer personnel files. All active volunteers and substance misuse staff had a current disclosure and barring service checks and all staff had two references, photographic identity, job descriptions, and contracts found within their personnel files.
- Communication between senior management and local management was not good and mis-communications had potentially serious consequences. Examples included, senior management had appointed a new nurse to start at the centre three days after the inspection. Senior managers had not communicated this to the registered manager. Therefore, there were no plans in place for her induction or orientation, and the manager was not aware of her skills, knowledge and experience. Also, due to senior management mis-communication staff believed there had not been any specialist clinical or medical out of hours cover during the previous six weeks.

**Leadership, morale and staff engagement**

- Staff morale at the service was good. Staff told us they felt valued and rewarded for the job they did. We saw positive interactions between staff members. Between November 2017 and June 2018 there were no unauthorised absences/ or sickness days taken by staff.
- The provider had a whistle-blowing policy. Staff told us they knew the whistle-blowing process and they felt able to raise concerns without fear of victimisation. None of the staff or managers we spoke with raised any concerns about bullying or harassment.
- Therapy staff provided leadership within the service. Staff felt the leadership of the service encouraged an open, supportive and honest culture.

# Substance misuse/detoxification

- Two staff members reported that they could input into the development of the team while others felt they could not, or that they would be not be listened to.

**Commitment to quality improvement and innovation**

- Senior management felt they were working towards quality improvement, in response to feedback from inspections and registration visits. They gave examples of the new organisational roles they had created around health and safety monitoring and compliance management. However, while we saw evidence of this we also saw that managers were not evaluating and checking the quality improvements for effectiveness. There were no staff reward or recognition schemes.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that they assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity, and include scrutiny to ensure compliance with the regulations.
- The provider must ensure that they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.
- The provider must ensure that their audit and governance systems remain effective, so they can provide a safe and effective service.

### Action the provider SHOULD take to improve

- The provider should ensure proper and safe management of medicines.
- The provider should consider harm reduction measures in respect of their practice to accept new referrals on a Friday morning for detoxification.
- The provider should consider inviting new clients to view the accommodation part of their service prior to signing admission agreements.
- The provider should have clear vision and values, to ensure staff and clients know what to expect of the service.

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 17 HSCA (RA) Regulations 2014 Good governance<br><br>**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance**<br><br>• Overarching governance of the service was not embedded practice. Management was not monitoring new guidance and policy to ensure it was working. Management was not evaluating and checking their quality improvements for effectiveness. The service did not have targets or key performance indicators. Quality assurance management and performance frameworks were not in place. The risk register was incomplete. Registered managers did not have sufficient time, authority or autonomy to carry out their duties effectively. Communication between senior management and location managers and staff was not always good. Not all recruitment processes were robust. The provider did not have clear vision and values.<br><br>• Poor cleanliness due to lack of monitoring in the communal kitchen area posed risk of infection for staff and clients. Managers had not included blind spots on the environmental risk assessment.<br><br>• Management had not completed clinical audits. We did not see any external audit of the processes relating to medicines management and dispensing medication for the three months prior to inspection.<br><br>• The medications policy did not reflect amendments to the health and social care regulations or current guidance around medication management. There was no controlled drugs accountable officer for the service, and the provider had not addressed the need to work in partnership with a local pharmacist, or the local controlled drugs accountable officer group.<br><br>**This is a breach of Regulation 17(1)(2)(a)(b)(f)** |

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.