PCP Leicester

Quality Report

158 Upper New Walk
Leicester
Leicestershire
LE1 7QA
Tel: 0116 2580690
Website: www.rehabtoday.com/leicester

Date of inspection visit: 04 - 05 November 2019
Date of publication: 01/01/2020

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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	Requires improvement

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 rated PCP Leicester as requires improvement because:

- The provider had not met legal requirements in relation to controlled drugs. Staff had not identified, through clinic room audits that the service was operating without a controlled drugs Home Office Stock licence between 30 August and 08 September 2019. This had not been picked up as part of the providers clinical audit process.
- Staff did not always respect client's privacy and dignity. We observed on two occasions that staff were taking clients physical observations in the reception area, even though there was a clinic room for these procedures to take place in private.
- Mangers did not formally supervise new starters they had been post for three months. While this was in line with provider policy and there were other informal measures in place to ensure staff were not left unsupervised during their first three-month probationary period. We had concerns as the impact of this could be that new staff may encounter skills deficits or develop poor practice before they were formally picked up through the supervision process.
- The provider did not always ensure the safe disposal of clinical waste. There was no yellow clinical waste bin in the clinic room, though there was one in the toilet where staff did urine testing. We raised this with the manager and before we left site she had ordered a second clinical waste bin.

However:

- The service was well led, and the governance processes had been reviewed to ensure that its procedures ran smoothly. Since our previous inspection the provider had restructured the service to include four senior managers including an operational manager, a health and safety manager, compliance manager and services manager. The registered manager no longer carried any clinical responsibility.
- The service provided safe care. The clinical premises where clients were seen were safe and clean. The service had enough staff, this was an improvement on our previous report. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the clients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Staff treated clients with compassion and kindness and understood the individual needs of clients. We heard some exceptional examples including how staff had supported and encouraged a client who wanted to leave on their first day at the service, the client decided to stay; staff liaising with a client's employer to keep their job open for them whilst they underwent treatment; staff supporting clients to regain contact with their estranged children and the provider extending a client's stay free of charge.
- Staff actively involved clients in decisions and care planning. Clients told us the service was easy to access. Staff planned and managed discharge well and had alternative pathways for people whose needs it could not meet.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Substance misuse services	Requires improvement 	Residential substance misuse service

Summary of findings

Contents

Requires improvement

PCP Leicester

Services we looked at: Residential substance misuse services

Summary of this inspection

Background to 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 Rebecca Crutchley, and a nominated individual. They did not have a controlled drugs accountable officer.

The service includes a treatment centre where clients attend daily therapy sessions, and a seven-bedded detoxification house, known as St Stephens for people undergoing detoxification with 24-hour supervision. St Stephens is separately registered with the Care Quality Commission, and although inspected alongside PCP Leicester it has been reported on separately.

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, seven people were accessing the service for day treatment. The length of stay for clients in treatment was between two and twelve weeks.

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 the midlands area.

The Care Quality Commission has carried out three inspections in November 2015, March 2017 and July 2018. Following the last inspection, we found the following practices needing action by the provider:

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance – Requirement Notice

- 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 enough 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 risk of infection for staff and clients. Managers had not included blind spots on the environmental risk assessment.
- 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.
- 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.

Furthermore, we asked the provider to consider action in respect of the following:

- 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.

At this inspection we found the provider had or were addressing all the above actions. How the provider addressed the issues is recorded in the detail below.

Summary of this inspection

To be noted: Since writing this report the provider has de-registered this service with the Care Quality Commission. This means the service no longer exists.

Our inspection team

Team leader: Debra Greaves

The team that inspected the service comprised two CQC inspectors and a specialist advisor nurse with specialist knowledge of substance misuse services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked other organisations for information and sought feedback from clients at quarterly engagement meeting drop in sessions.

During the inspection visit, the inspection team:

- visited PCP Leicester treatment hub looked at the environment and observed how staff were caring for clients
- spoke with six clients who were using the service and three clients who had previously used the service and two carers
- spoke with the registered manager and three other senior managers
- spoke with five other staff members; including doctors, nurses, counsellors and support workers and administration staff
- attended and observed one admission meeting and one medical review meeting
- collected feedback from 15 feedback forms and cards
- looked at six care and treatment records, including medicines records, for clients
- carried out a specific check of the medication management
- reviewed five staff files
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- We spoke with six current clients, three clients who had previously used the service, two carers and reviewed 15 client feedback forms. Most were positive about the support they had received from the service, telling us that it had saved their life, helped them get their life back and helped them to see that there was life after addiction.

Summary of this inspection

- Clients told us that staff were available 24 hours a day, they felt safe and supported, were involved in their care plan and felt that all their needs were met.
- Clients who had left the service told us that the aftercare support was useful.

However:

- Some clients told us that the accommodation part of the service was cramped, and they had to wait to use the cooker to prepare their evening meal.
- One client told us they had not received much information before starting the treatment programme.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as Good because:

- All areas where clients received care and treatment were clean, well furnished, well maintained and fit for purpose. There was a ligature audit and mitigation for the ligatures had been identified. Staff were aware of blind spots. There was a further environmental risk register. This was an improvement on our previous inspection.
- The service had enough nursing and medical staff, who knew the clients and received basic training to keep them safe from avoidable harm. This was an improvement on our last inspection visit.
- Staff screened clients before admission and only offered admitted them if it was safe to do so. Only fewer complex clients were admitted on a Friday morning, this was an improvement on our last visit. Staff assessed and managed risks to clients and themselves well. They responded promptly to sudden deterioration in clients' physical and mental health.
- Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service had a good track record on safety.

However:

- There was no yellow clinical waste bin in the clinic room. Staff were using a regular waste bin with no yellow liner, though there was a clinical waste bin in the disabled toilet where urine testing was carried out. We made the manager aware of this, and before we left she showed us the order for a second clinical waste bin.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Managers did not offer new starters formal supervision until three months after they had started in post. The impact of this could be that new staff may encounter skills deficits or develop poor practice before they were formally picked up through the supervision process.

However:

Summary of this inspection

- Staff assessed clients physical and mental health needs before, during and after admission. All clients had comprehensive person centred and holistic care plans. Staff considered clients social, domestic cultural and spiritual needs.
- Staff addressed physical healthcare needs such as epilepsy and diabetes. Staff had received additional training to be able to understand and work with these conditions.
- The provider had revised the service model to a biopsychosocial model of delivery underpinned by 12 step model for treating addiction. Treatment was delivered in accordance with National Institute for Health and Care Excellence guidelines.
- The manager carried out relevant audits and any findings were acted upon to improve care and treatment. Other staff carried out health and safety, therapy and clinical audits. This was an improvement on our last inspection.
- Managers provided specialist training to all staff as and when supervisors or staff identified training needs.
- Staff had undertaken Mental Capacity Act training and knew how the Act applied to their roles.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Staff did not always respect client's privacy and dignity. We observed on two occasions that staff were taking clients physical observations in the reception area, even though there was a clinic room for these procedures to take place in private. We observed on two occasions that staff were taking clients physical observations in the reception area. Although there were no other clients in the room at the.

However:

- We saw staff speaking with clients in a caring manner and treating them with kindness. Clients reported that staff treated them well and respected their wishes. A peer support buddy system was in place for clients to support them through their recovery. The service used a rule of three people being together whenever they left the accommodation to prevent clients from being tempted to relapse. We heard positive examples from clients about exceptional care and support they had received from staff.
- Staff actively involved clients in the planning of their care. Support staff were available to support and encourage clients with their evening diary work. Clients had copies of their care plans and these were reviewed regularly.

Summary of this inspection

- The provider offered a monthly facilitated friends and family support group. The provider invited clients and family members to give feedback about the service through end of treatment surveys and an annual feedback survey.

Are services responsive?

Good

We rated responsive as good because:

- The service was easy to access. Staff planned and managed discharge well. The service had alternative care pathways and referral systems for people whose needs it could not meet.
- The design, layout, and furnishings of the centre supported clients' treatment, privacy and dignity. There were enough private and soundproofed group and therapy rooms for client's treatment sessions. There was a well-equipped clinic, a lounge for clients to relax between therapy sessions and a kitchenette where clients could make hot drinks and snacks. At the accommodation each client had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service met the needs of all clients, including those with a protected characteristic or with communication support needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The provider had not met legal requirements in relation to controlled drugs. Staff had not identified, through clinic room audits that the service was operating without a controlled drugs Home Office Stock licence between 30 August and 08 September 2019.

However:

- The service was well led, and the governance processes had been reviewed to ensure that its procedures ran smoothly. Since our last inspection the provider had restructured the service to include four senior managers including an operational manager, a health and safety manager, compliance manager and services manager. The registered manager no longer carried any clinical responsibility.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for clients and staff.

Summary of this inspection

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. This was an improvement on our last inspection.
- Teams had access to the information they needed to provide safe and effective care and used that information to good effect. All staff had a tablet with real time access to clients care notes, risk assessments and other information to help them in their work roles.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety four percent of staff were trained in and had a good understanding of the Mental Capacity Act. There was one staff member who was waiting to complete her training in November 2019. There was a Mental Capacity Act policy in place that staff could refer to if necessary. Staff we spoke with understood their responsibilities under the Mental Capacity Act and knew how the act impacted on their work role. There were no clients subject to Deprivation of Liberty Safeguards.

There was evidence in care records that capacity had been assessed and consent to treatment had been gained. Clients signed a treatment contract on admission to the service. Staff told us that clients could temporarily lack capacity due to being intoxicated, in these situations they would wait until the client was not under the influence of alcohol or drugs.

Requires improvement

Substance misuse services

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

Are substance misuse services safe?

Good

Safe and clean environment

All clinical premises where clients received care were clean, well equipped, well furnished, well maintained and fit for purpose. Since our last inspection the provider had invested in refurbishment at the treatment hub, appointed a senior manager for health and safety across all the PCP locations. They were supported by a health and safety officer at each location. The health and safety manager had introduced more robust cleaning and health and safety audits and check lists, and a maintenance tracker.

The service had an up to date health and safety and fire risk assessment in place.

There was a ligature audit and mitigation for the ligatures had been identified. Staff were aware of blind spots. This was an improvement on our last inspection. There was a further environmental risk register identifying other hazards such as the building works currently being undertaken in the back courtyard / car park / smoking area. The provider had identified issues waiting to be addressed, these included water temperature restrictors on hot taps, covers on exposed radiators and a water leak on the top landing.

The clinic room and equipment were clean, checked and maintained.

Safe staffing

The service had enough nursing and medical staff, who knew the clients and received basic training to keep them safe from avoidable harm. Staffing levels and skill mix had improved since our last inspection. Staff's roles were now clearly defined but allowed for overlap between 5.00pm and 9.00pm each evening when there was just one support worker, to ensure safe coverage, until the sleeping support worker was on shift at 9.00pm.

At the time of inspection, the manager confirmed the service had three whole time equivalent counsellors, five whole time equivalent recovery support workers, and a full-time nurse. In addition, there were two GP's, with an interest in substance misuse, for three half day sessions per week, three volunteer trainee counsellors, plus administration and housekeeping staff. Staff turnover between April 2019 and July 2019 had been three staff members, though one staff leaver subsequently returned to take up a new post, and one staff member had been on sick leave for four days.

For a period of two months, April to May 2019 (44 shifts) the service had used a block booked agency nurse to fill the gap between one nurse leaving unexpectedly and the current nurse starting.

There was robust management out of hours cover for emergencies in the evenings and weekends when the predominant staff on shift were support workers. Out of hours medical clinical cover had been clearly defined. The clinical nurse lead was available for any out of hours queries. All other out of hours clinical medical issues were through 111, 999 or the local walk in centre.

The provider could use the PCP floating nurse for cover in the absence of their own nurse who was now full time. Managers could use PCP bank staff if the need arose, and staffing levels now provided for PCP Leicester to have its own floating bank staff member.

Requires improvement

Substance misuse services

Mandatory training rate was 92%. Most mandatory training was via e learning and the courses were delivered by approved and accredited training organisations. The contract PCP limited had with the organisation included ongoing training materials, competency monitoring tools, advice and refresher training as required. In addition, the onsite nurse and therapy counsellors offered bespoke training for staff as needs arose.

Assessing and managing risk to patients and staff

We reviewed six client risk records on the electronic database. All records showed that staff completed comprehensive risk assessments at the point of admission and they were regularly reviewed as a multidisciplinary team activity.

Individual client's risk was discussed in daily handover meetings and through the sharing of clients self-completed journal meetings. Staff followed the orange book clinical guidelines updated in 2017, in relation to risk assessments and risk management. Staff had updated the risk assessments following incidents and changes in the client presentation.

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

The admissions process included robust risk assessment both pre-admission and during the admission assessment. The admission process, particularly for clients requiring detoxification, had been revised and now required two levels of scrutiny and a multidisciplinary team approach to admission.

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

Safeguarding

There had been no safeguarding concerns raised for the period 30 July 2018 to June 30, 2019. Staff understood how to protect clients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff understood safeguarding and how to make raise a safeguarding concern. The registered manager and lead therapist had both undertaken additional safeguarding training with the local authority and were the services nominated safeguarding leads.

Staff told us that in many situations where safeguarding may be an issue client already had social workers involved and the client's focal counsellor, or nurse if it was known at admission, ensured they contacted the social worker.

Staff access to essential information

All client information was now on electronic record and staff had tablets so that they could view and input client data in real time, this was an improvement since our last inspection. Staff reported that this had made their access to client's risk assessments, risk management plans and care plans much easier and they felt they were able to deliver safer care as a result. They also felt it helped them to maintain high quality clinical records.

Medicines management

The service used systems and processes to safely prescribe, record and store medicines. The service now had a formal contract with an external pharmacist to scrutinise their medicines audits. Medicines policy now reflected the amendments to the health and social care regulations and current guidance for treating substance misuse.

Staff regularly reviewed the effects of medications on each client's physical health. All staff had now completed accredited medicines management training.

There was no yellow clinical waste bin in the clinic room. Staff were using a regular waste bin with no yellow liner, though there was a clinical waste bin in the disabled toilet where urine testing was carried out. We made the manager aware of this, and before we left she showed us the order for a second clinical waste bin.

The service used controlled drugs, and although the service did not have an accountable controlled drugs officer, the nurse, clinical lead nurse and registered manager all linked in with the local controlled drugs accountable officer meeting. There was external scrutiny of medicines practice by an external pharmacist, albeit this was annually. We had it confirmed via copies of e mails that these arrangements had been agreed as adequate between PCP, their other locations and the Care Quality Commission.

Requires improvement

Substance misuse services

Track record on safety

The service had a good track record for safety. Between June 2018 and July 2019 there had been one serious incident. This had involved a client becoming unwell during treatment and requiring hospitalisation.

Reporting incidents and learning from when things go wrong

The service managed client safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. We saw minutes of team meetings, and local and organisational clinical governance meetings attended by managers where they discussed incidents and learning had been disseminated to all the PCP locations.

We saw evidence of change having been made a result of this learning including enhanced and revised audit processes, review and revision of what should be discussed in team meetings and only admitting less complex clients on a Friday morning.

We saw evidence in the providers response letters and recording documentation that when things went wrong, staff apologised and gave clients honest information and suitable support.

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

Requires improvement

Assessment of needs and planning of care

We reviewed six clients care records, all records were in date and comprehensive and included clients physical, psychological, and social care needs. Care planning was much improved since our last inspection and clearly identified the client's input.

Staff completed assessments with clients on admission to the service, and clients were encouraged to complete self-evaluation forms to help inform their care planning. Care plans reflected the clients assessed needs, and risk management plans, and were personalised, holistic and recovery-oriented. All clients were allocated to a focal counsellor who ensured that the plans were updated regularly.

Health screening and physical health observations was routinely used as part of the clients care and treatment.

Best practice in treatment and care

Staff followed doctor's instructions on administering medication and had been trained using Royal College of General Psychiatry online medication management training. The nurse at PCP Leicester treatment centre completed staff medication management competency assessments.

Staff provided a range of care and treatment interventions suitable for the client group and consistent with National Institute for Healthcare and Excellence guidance to inform their alcohol and opiate detoxification protocols and best practice. They ensured that clients had access to physical healthcare and supported clients to live healthier lives. The manager told us that following a therapy review of the service offered by PCP Leicester they now described their treatment intervention as a bio-psychosocial approach underpinned by the 12-step abstinence program.

Staff used recognised rating scales to assess and record severity and measure outcomes, such as the Severity of Alcohol Dependence Questionnaire (SADQ) and the Clinical Opiate Withdrawal Scale (COWS). Staff at St Stephens referred to care plans that were informed by the regular use of outcome measures.

Skilled staff to deliver care

Staff we spoke with told us they received an appropriate induction. We saw a blank induction check list that covered all the key information staff needed to work safely in the first few weeks of their employment. Staff confirmed they had competed induction including shadowing, mandatory training and orientation to the service, however, we were unable to locate copies of induction check lists in staff files. Staff also had opportunity to shadow more experienced colleagues and one newly recruited staff member confirmed they had just completed ten shifts of shadowing.

Requires improvement

Substance misuse services

Data showed that the compliance rates for supervision was 89%. Counsellors had monthly clinical supervision which was more than the providers policy stated. The policy stated that staff should receive managerial and clinical supervision quarterly and an appraisal annually.

We were concerned that new starters did not receive their first formal supervision session for three months. The impact of this could be that new staff may encounter skills deficits or develop poor practice before they were formally picked up through the supervision process The manager explained that while new starters did not have formal supervision for the first three month of their contract, they did have access to informal supervision discussions and performance monitoring. New staff were paired up with a more experienced staff member and spent several weeks shadowing other colleagues doing the same job role as themselves.

We reviewed staff files for five staff who worked at PCP Leicester. Three of the staff had started working at the service less than three months ago and had not received one to one supervision yet, though we saw that dates had been booked. One staff member who recently started had received one supervision, and the manager supervised the remaining staff member in line with policy.

While the nurse had received regular management supervision, she had only received one clinical supervision since taking up post in May 2019. The reason was because the nurse's clinical supervision was to be completed by the organisations clinical nurse lead who had only been in post for two months. Staff told us they were happy with the level of support they received.

We were concerned that of the five staff only one had previous professional experience of working in a substance misuse service. However, training records showed that all staff had received additional training and informal peer support. Additional training included safe detoxification, observation, diabetes awareness, suicide prevention, motivational interviewing, food hygiene, preventing radicalisation, complex needs and dual diagnosis, risk assessment, care planning, epilepsy and self-harm. Staff themselves did not feel this was a problem and had always felt informed and supported.

Staff knew how to access emergency physical and mental healthcare treatment for clients via the local NHS walk in clinics, A&E or Mental Health Crisis Team.

Multi-disciplinary and inter-agency team work

All staff including night time support staff attended twice daily, morning and late afternoon, handovers, de briefings and risk management meetings.

The team included or had access to the full range of specialists required to meet the needs of clients under their care. Managers made sure that staff had the range of skills needed to provide high quality care.

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

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Provider responsibilities under the Mental Health Act were not applicable to this service

Good practice in applying the Mental Capacity Act

Ninety four percent of staff were trained in and had a good understanding of the Mental Capacity Act. There was one staff member who was waiting to complete her training in November 2019. A Mental Capacity Act policy in place that staff could refer to if necessary. Staff we spoke with understood their responsibilities under the Mental Capacity Act and knew how the act impacted on their work role. There were no clients subject to Deprivation of Liberty Safeguards.

Staff evidenced within care records that capacity had been assessed and consent to treatment had been gained. Clients signed a treatment contract on admission to the service. Staff told us that clients could temporarily lack capacity due to being intoxicated, in these situations they would wait until the client no longer under the influence of alcohol or drugs.

Are substance misuse services caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Requires improvement

Substance misuse services

We saw staff speaking with clients in a caring manner and treating them with kindness, dignity and respect. Clients reported that staff treated them well and respected their wishes.

A peer support buddy system was in place for clients to support them through their recovery. The service used a rule of three people being together whenever they left the accommodation to prevent clients from being tempted to relapse.

We spoke with six clients currently using the service, 3 ex clients, two carers and reviewed 15 client feedback forms. We heard positive examples from clients about exceptional care and support they had received from staff. These included staff providing additional support and encouragement to a client who wanted to leave on their first day at the service, the client decided to stay; staff liaising with a client's employer to keep their job open for them whilst they underwent treatment; staff supporting clients to regain contact with their estranged children and the provider extending a client's stay free of charge.

Staff would support clients with children to keep in contact with them by providing access to their mobile phone.

The nurse included the view point of the primary carer or clients next of kin on the pre-assessment form, if the client had given written permission for this in their application form.

The provider sought consent from clients on the treatment contract, which included what information they were happy for the staff to share and who with.

However, we observed on two occasions that staff were taking clients physical observations in the reception area, even though there was an adequate clinic room for these procedures to be done in private. While we noted there were no other clients in the room at the time and the room had an automatic locking door, the procedure took place in front of the client's escort and could be observed from the reception hatch. Other staff, not directly associated with the procedures, were present in the area at the time. When this was mentioned to the nurse she told us that the doctor was using the clinic and she did not want to disturb him.

Involvement in care

Clients were actively involved in the planning of their care. All clients were allocated to a focal counsellor, who facilitated their one to one session throughout their stay at the service. Support staff were available to support and encourage clients with their evening diary and journal work.

Clients had copies of their care plans and these were reviewed regularly.

Clients could give regular feedback about the care they received via community meetings and client feedback sessions.

Staff advised that the service did not access any local advocacy services and that clients were expected to access advocates for themselves, though information regarding a list of local advocates was available in the information pack and displayed in the foyer area of the treatment centre.

The provider offered a monthly facilitated friends and family support group.

The provider invited clients and family members to give feedback about the service through end of treatment surveys and an annual feedback survey.

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

Good

Access and discharge

There was a clear access and discharge policy and criteria. There were clear pathways for managing transition through the service and for managing client's changing needs.

Access to the service and discharge from the service was well planned. The provider had recently strengthened the admissions process to ensure as much information as possible was gathered at the pre-assessment stage.

The service did not use a waiting list when we visited and did not accept emergency admissions, only admitting clients on one of the three days a week that the doctor was at the service.

Staff planned for early exit from treatment at the assessment stage including taking details of who should be contacted if a client relapsed or discharged themselves from treatment early.

Requires improvement

Substance misuse services

The service responded promptly to referrals usually arranging admission within a few days but only admitting when a doctor was available to complete the initial assessment. For the period 30 September 2018 to 08 August 2019 there had been 45 admissions. Of which 34 clients were discharged at the end of treatment, and four had discharged before the completion of treatment.

Clients and carers told us they had found accessing the service very easy, they liked the on-line application process and the speed with which their applications were processed. They felt staff were very knowledgeable about them when they got to the treatment centre for their assessment.

The service provided an aftercare group that was open to clients for as long as they needed

The facilities promote recovery, comfort, dignity and confidentiality

The facilities at the treatment met the needs of the clients. There were adequate group therapy rooms, private one to one counselling rooms and a well-equipped clinic. There was a lounge area and kitchenette away from the therapy rooms where clients could relax between treatment sessions.

Patients' engagement with the wider community

Clients were encouraged to maintain their family, social and work contacts while undergoing treatment. Clients were supported to develop or reconnect with contacts that they may have previously allowed to lapse.

During their treatment clients were encouraged to develop community support networks in the area where they would be residing after treatment. Staff were proactive in helping people access local support groups when they moved on from the service.

Staff had a good awareness of local services available to meet patient's needs.

Staff made efforts to contact support groups local to the client so that they could continue their recovery on discharge.

Meeting the needs of all people who use the service

There was an up to date equality and diversity policy. Staff had access to service specific training that met the needs of service users e.g. dual diagnosis, equality, diversity and human rights and working with the needs of specific groups e.g. lesbian, gay, bi-sexual and transgender people; black and ethnic minority groups, older people, victims of abuse, sex workers and young people.

Staff were able to tell us about the fundamental human rights that applied in their work.

All clients were expected to be self-catering and so individual dietary needs were always catered for. All clients had their own comfortable bedroom with a work desk and a safe to lock away their valuables, though the client's accommodation was in a different building to the treatment centre, it has separate registration and therefore is reported on in a separate report known as St Stephens.

The treatment hub was located over three floors of a town house with no lift, and the service could not provide disabled access. Managers told us that if someone with a disability wanted to access the service they could do so at one of their other centres.

Staff gave all clients an information pack at the point of admission. This pack included details about the service and the staff, guidance for the first days in treatment, expectations for both staff and client, information about treatment options, inclusion, client's rights to leave treatment, and how to make a complaint or compliment. In addition, we saw information in the foyer of the service about health and safety, Mental Capacity Act, and advocacy.

Staff told us they could provide information leaflets in other languages, and interpreters could be arranged at additional cost to the client.

Staff had supported clients to access support for their spiritual needs through attendance at places of worship.

Listening to and learning from concerns and complaints

For the period 30 July 2018 to 08 August 2019 the service received two complaints and fifteen compliments. All complaints had been escalated as per provider policy, investigated, reported upon as per provider procedures and resolution letters had been sent to the complainants. We saw evidence of minutes from community meetings, feedback forms and "you said we did" where clients had raised issues, and these had been addressed. Issues such as conditions in the house, regularity of one to one session and staffing at the house during weekends.

Requires improvement

Substance misuse services

Staff told us they would try and resolve complaints locally, if this was not possible it would be escalated to the registered manager and head office to be investigated.

Clients told us they felt comfortable to raise concerns in the weekly community meetings and that any concerns raised were responded to quickly.

Staff told us they received feedback on the outcome of investigation of complaints in team meetings. Clients were provided with information on how to complain on admission and could complain at community meetings, individual sessions or directly to the registered manager.

Are substance misuse services well-led?

Requires improvement

Leadership

Leadership had improved since our last inspection. The introduction of a senior management team with overarching responsibility for all the PCP locations was making a significant improvement with consistency and communication. This team of senior managers were also able to offer registered managers more support and guidance. The decision to have the registered manager just doing management meant that overarching governance within the location was more robust.

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

Vision and strategy

There was a clear vision and set of values which staff knew and understood and applied in the work. This was an improvement on our last inspection. PCP had a staff charter that set out the values and behaviours expected of all staff towards each other and clients.

Culture

There was a culture of wanting to learn and provide high quality treatment and therapy for

clients.

Staff felt respected, supported and valued. Staff who had been in the organisation for some time, told us things had improved significantly in the last six months or so.

Staff reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution. All staff we spoke with knew about the providers whistleblowing policy and how to use it.

Governance

Governance at both organisational level and local level had much improved. The provider held quarterly clinical governance meetings with head office staff and the senior management team, and registered managers. As well as providing guidance for registered managers the meeting considered practice and policy, complaints and concerns, incidents reports and shared learning across the organisation. This meeting was preceded by a nurses meeting to pick up any current clinical and nursing issues. At local level there were monthly, clinical governance meetings weekly team meetings and twice daily handover meetings from night staff to day staff and vice versa.

The new senior team had analysed existing systems and procedures of governance and revised all previous policies relating to governance. As a result, they had introduced a range of refined tools including audits and checklists to be used by registered managers and staff at local level to ensure better consistency and thoroughness of their governance processes.

However, we found the service had been operating without a controlled drugs Home Office stock licence between 29 July and 08 August 2019. Staff had not identified this omission during their daily and weekly clinic audits. During this period time staff had been administering controlled drugs including Methadone without the legal authority to do so. Having a valid and in date Home Office Stock license means that when presented with unforeseeable risks, such as an alcohol dependent person in severe withdrawal upon admission to the service, staff can administer controlled drugs from stock, under Dr's instructions to reduce risk of alcohol withdrawal related complications.

Management of risk, issues and performance

The managers were managing environmental and clinical risks well. The local risk register matched the

organisational risk register, this was an improvement on our last inspection. Managers were addressing poor performance in line with the providers policy and sensitively. The provider had introduced regular staff competency monitoring.

Systems to collect risk information and escalate issues were clearly defined at all levels of the organisation. The introduction of a more streamlined governance meeting structure enabled issues to be addressed at a much earlier opportunity and communication of risk and issues across the organisation was much improved than we found at our last inspection.

We reviewed five staff files and found all had relevant disclosure and barring Certificates and when necessary employment risk assessments.

Information management

Registered managers had easy and reliable access to the information they needed to provide safe and effective care and used that information to good effect. The service had invested in new data bases to improve managers access to information, Data bases included the use of an electronic database to capture client assessment and data; a shared drive for day to day documentation, reports and health and safety records; and an external web-based system to manage human resources including on-line HR management advice and training materials.

All staff could access client information including care records and risk assessments in real time using personal tablets and an app on their smartphone. Staff told us this had made their jobs much easier and safer, they felt it helped them to provide high quality care.

Engagement

Engagement with commissioners and statutory services was much improved. Managers at senior and local level were expected to forge links and attend regular meetings with statutory services both in the Leicester area and where possible in the client's home communities. For example, we heard reports of focal counsellors contacting a client's social worker to facilitate parental contact with her children.

The providers engagement with Care Quality Commission at quarterly engagement meetings had been exemplary and productive.

Learning, continuous improvement and innovation

We saw evidence that supported what we had been hearing during our engagement meetings about audit projects and the formulation of governance documents, revision of policies and introduction of electronic data bases and improved and enhanced auditing tools.

Key performance targets were clearly identified and being met. Examples included Health and Safety compliance rates, throughput, early discharge rates, and re-referral rates.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they always have a valid and in date Controlled Drugs Home Office licence.
- The provider must ensure that client's privacy and dignity is always maintained.
- The provider should ensure that all new starters have adequate and recorded supervision during their first three months of employment.

Action the provider SHOULD take to improve

- The provider should ensure that there is always a yellow clinical waste bin in the clinic.

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 10 HSCA (RA) Regulations 2014 Dignity and respect We observed on two occasions that staff were taking clients physical observations in the reception area, even though there was an adequate clinic room for these procedures to be done in private. This was a breach of regulation 10(1)(a).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in safe way for service users, including the safe management of medicines. The provider was administering controlled drugs without a valid home office licence during the period 30 July 2019 to 8 August 2019. This was a breach of regulation 12(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We were concerned that new starters did not receive their first formal supervision session for three months. The impact of this could be that new staff may encounter skills deficits or develop poor practice before they were formally picked up through the supervision process. This was breach of regulation 18(2)(a)