Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Greenwich Primary Care Drug and Alcohol Service

821 Woolwich Road, Charlton, London, SE7 8LJ

Date of Inspection: 14 January 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	CRI (Crime Reduction Initiatives)
Registered Manager	Mr. Wayne Ronald Butcher
Overview of the service	Greenwich Primary Care Drug and Alcohol Service is a centre that offers a treatment programme for individuals with substance misuse issues. The service includes two walk-in sessions a week where no appointment is needed, a prescribing service, and access to a team of drug and alcohol workers who provide information and advice that will enable individuals to make informed choices and reduce risks to their health and wellbeing.
Type of service	Community based services for people who misuse substances
Regulated activities	Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

Records we reviewed showed that people had to sign consent forms giving the service permission to share information about the treatment they were receiving with various outside organisations such as the persons GP and social services.

One person told us "They have helped me more than anything and have gone out of their way to help me sort things out." Another person said "This is the second time I have come back here and I only came back so quickly because my previous experience was so good."

There were effective systems in place to reduce the risk and spread of infection. Staff we spoke with said that cleaning was undertaken daily by contract cleaner.

The provider had a supervision policy which stated that the staff were to receive supervision at least nine times within the year. This could be a combination of group activities, workshops or one to one supervisions.

People's personal records including medical records were accurate and fit for purpose. We looked at the paper files for ten people who used the service. The paper file which contained information such as their care plan, needs assessments, risk assessments, treatment programmes and prescriptions.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone

number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Records we reviewed showed that people had to sign consent forms giving the service permission to share information about the treatment they were receiving with various outside organisations such as the persons GP and social services. People were also required to sign programme treatment agreement forms which outlined the details of the treatment they would receive and provided consent that they would comply with the programme. We reviewed the files for ten people using the service and found that they all contained both signed consent forms and signed treatment agreements.

We spoke with two people who used the service about consent. One person told us that they could not remember if staff had asked them to sign consent forms but they were sure that if they had been they would have signed them. Another person said that they had signed some paper work consenting to receive help from staff with their recovery programme.

We spoke with four members of staff about consent. The registered manager told us that consent was gained when the initial assessment was carried out. Staff would explain to people with whom and why the information had to be shared. The consent form did highlight that it was not possible to use the service if the person did not consent to information sharing with their GP. This was because it was important that the service was able to have accurate information about people's medical history when prescribing medication. Three members of staff told us consent was regularly reviewed with people and initially discussed during the first assessment. We saw in one person's file that they had given consent to information sharing with various parties on different dates.

We asked staff what they would do if people appeared to lack capacity to give consent when attending for appointments and assessments. One person told us that at times people came to appointments under the influence of illicit drugs or alcohol. On these

occasions provisions would be made to rearrange the appointment. Another said that if they had any concerns they would speak to the doctor based in the service and another person said they would try to explain things in a clear and simple manner. This was because at times people's ability to understand information was affected by how the information was being passed on.

We asked the registered manager if the provider had a consent policy in place. They told us that the organisation did not have a specific policy on consent but people came to the service either voluntarily or because of a court order. For people with a court order in place compliance with the treatment programme and consenting to treatment was compulsory.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We reviewed the files for ten people who used the service. These showed that people had to have an initial needs assessment which looked at various areas such as their use of alcohol, drugs, mental health, family situation, housing and finances. One member of staff told us that this allowed the service to see whether people needed support from other external agencies such as the DWP or housing. People were also required to attend a full medical check with the service's doctor and the service liaised with people's GP's to get further information on their medical history. A care plan would be then be created and it would be discussed with the person about what treatment they could receive. Records we reviewed showed that people attended groups and one to one sessions to address areas which had been identified in their care plans. For example one person's care plan said that the person would reduce their use of a particular illicit substance. This would be achieved by the person engaging in group therapy, taking their medication and attending appointments with the doctor. We saw in another person's file that when they had not been attending appointments, staff had attempted to contact them and arrange meetings to address how they could help the person follow their treatment programme.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw evidence in the files we looked at that people had risk assessments and risk management plans in place. The risk assessments and risk management plans looked at areas such as substance misuse related risks, risk of harm to others and physical health. They also provided direction for staff and the person on how to manage or minimise the risk. For example one person who was at risk of relapse was encouraged to attend their relapse prevention appointments and staff were encouraged to educate them on their drug use and how it affected them.

We spoke to three people who used the service. One person told us "They have helped me more than anything and have gone out of their way to help me sort things out." They also said "Coming here stops me being bored and it has been good for me here, I have been to other places, but here you walk in and you feel safe and welcomed." Another person said "They say I can change, we talk about change here." Still another said "This is

the second time I have come back here and I only came back so quickly because my previous experience was so good. All the staff I have met here have been nice, you really feel like they are rooting for you and have my best interests at heart."

Two people we spoke with who used the service told us that they felt staff treated them with respect and dignity and did not talk down to them. We spoke to staff about treating people with respect and dignity. One person said they were conscious of the language they used and the tone of their voice. Another said that they looked at people's cultural needs and ensured they took these into account when supporting people. They also said that they were conscious of the language that they used and they were sensitive with people who had children and how they felt about coming to the service.

We observed during our visit that staff spoke to people in a very friendly manner. People in the communal areas appeared to be comfortable and relaxed. We noted that people went into the communal kitchen and made themselves tea and coffee.

There were arrangements in place to deal with foreseeable emergencies. We were given a panic alarm to take with us when speaking to people and we were told by the registered manager that staff took these into each appointment or session with people. This was in case of staff needing support to deal with a situation. Staff we spoke with said that in the event of an incident they would summon for help. They also told that that if they felt medical attention was needed they would call the doctor or nurse. We spoke to one of the nurses who told us that the emergency services would be called if necessary and a person could be sent to A&E as a result. Staff said that after any incident they would write up the person's case notes with the details and also complete an incident form. We saw the provider's incident procedure which detailed how each type of incident should be dealt with for example who needed to be notified if a member of staff received a needle stick injury or a person who used the service had died. We also saw a copy of the incident form which allowed the full details of the incident to be recorded such as action taken including if any practices within the service needed to change.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

On the day of our visit we were taken on a tour of the building and went into two toilets. The building and toilets were clean and tidy.

There were effective systems in place to reduce the risk and spread of infection. Staff we spoke with said that cleaning was undertaken daily by contract cleaner. The did not detail the cleaning which had to be completed but stated that all cleaning undertaken would be in line with any legal requirements. We asked to see the completed cleaning schedules, but were told that the cleaner did not have to complete anything on each visit. The registered manager told us that staff also were responsible for house-keeping and tidying things away at the end of the day. Staff we spoke with also confirmed this and that all staff took turns with house-keeping. We saw the staff house-keeping rota for one month which showed who was responsible for each day of the month the service was open. The registered manager said that they would look into introducing a cleaning checklist to confirm the cleaning which had been completed. We asked the registered manager about the use of a colour coded system for cleaning the various areas. They said they were not able to confirm this but would take this up with the cleaning company. We did not see evidence of a colour coding system with the cleaning materials when being shown the cleaning cupboard.

The registered manager said that they also checked the cleaning which had been done and would raise concerns when necessary with the contractor, but they had no formal process for recording their checks. Staff we spoke with said that nurse also had responsibilities for cleaning the clinical areas and they completed a cleaning checklist. We reviewed the nurses cleaning checklist for six months and found that these contained duties such as checking the clinical bin had been emptied and whether the bin lid had been swabbed.

The nurse told us that they were also responsible for carrying out weekly checks on the balance of gloves and sharps bins in storage. We saw the completed weekly checklists for six months and these highlighted when staff were required to items.

Records showed that a six monthly health and safety audit was completed which looked at certain areas of infection control, such as whether clinical waste bins were in working order and whether all rooms in the building were in a clean condition.

The provider had a Control of Substances Hazardous to Health (COSHH) folder which detailed information such as identified hazards, composition of products and first aid measures. We observed that all COSHH products were kept in locked cupboards.

The provider had an infection control policy in place which stated that all staff were expected to follow good infection control principles. The policy also gave details of good basic hand hygiene and the use of personal protective equipment (PPE), such as gloves and aprons.

Staff we spoke with said that they used PPE when dealing with people where necessary. We saw in the clinical consultation and treatment room that there were adequate supplies of gloves, tissues and anti-bacterial gel, sharp bins and syringes. The room also contained a hand-washing basin. The nurse said that clinical waste was emptied on a daily basis into a larger locked bin outside the building and all clinical waste was collected fortnightly. This meant that there were effective arrangements for managing waste.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

The provider had a supervision policy which stated that the staff were to receive supervision at least nine times within the year. This could be a combination of group activities, workshops or one to one supervisions. It also stated that supervision should use the present to help staff reflect and learn from the past and make fresh commitments. We saw the supervision notes for five members of staff and these documented the training that people wanted to complete and had completed, such as safeguarding and a Diploma in Substance Misuse.

Staff said that they received supervision on a monthly basis and felt comfortable talking to their line manager if they had any concerns or the nurse or doctor. Records showed that people's line managers addressed issues which could affect people's performance, during supervision. For example we saw where one member of staff had raised a concern and this had been addressed.

Staff were able, from time to time, to obtain further relevant qualifications. The registered manager was able to show us the different training that people had undertaken, including First Aid at Work, Mental Health Awareness, Drugs Awareness, although we noted from the records of twelve members of staff that not all staff working for the service had attended these training sessions. They also explained that staff were able to access training through the provider intranet. Two members of staff we spoke with said they had completed various training courses with the service provider such as acupuncture and seminars on drugs. Another staff member who was a locum said they did not have access to the provider's training but completed external training as part of their professional registrations requirement for continual professional development.

We looked at the appraisals records for five members of staff. We saw evidence that the appraisal process allowed staff to discuss the details of additional support they needed. Records showed that staff had achieved some of the goals outlined in their appraisals.

These measures meant that staff had the opportunity to reflect on their practice and to identify any learning and development needs.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

People's personal records including medical records were accurate and fit for purpose. We looked at the paper files for ten people who used the service. The paper file which contained information such as their care plan, needs assessments, risk assessments, treatment programmes and prescriptions. There were also copies of correspondence sent to external agencies and other professionals involved in the persons care. The service also had an online case notes management system, which required all contacts with people to be updated on the system. We looked at the case notes for one person and found that details of group sessions, telephone contacts and letters had been logged on the system.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. We reviewed five staff paper supervision files and found that these files contained information regarding peoples' supervisions and appraisals. The registered manager told us that staff's main file was stored with the provider's HR department. We were also shown the providers online training records for twelve members of staff which showed training staff had undertaken.

Records were kept securely and could be located promptly when needed. During our visit we noted that confidential files were kept in locked cabinets when we went on a tour around the building. The registered manager told us that staff had access to the files of people who used the service and these were kept in a locked cupboard in the building. There was also different computer logins on the computer for staff and management and we noted this when we were shown some of the online information necessary for our visit.

The registered manager told us that if paper work needed to be destroyed it was put in a special bin. This was then collected and shredded by a contractor. Staff we spoke with confirmed this.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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