No 4

Quality Report

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Date of inspection visit: 1 October 2019
Date of publication: 15/01/2020

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

Overall summary

This was an unannounced focused inspection looking at progress the provider had made in addressing breaches found at our last inspection in May 2019. We did not rate the service as a result of this inspection.

We found areas of practice that require improvement.

- The service's governance processes were not yet fully embedded. It was not clear where responsibility for assurance lay. For example, what level of meeting issues were discussed and actioned at.
- Some of the provider's quality and safety data, for example data on staffing and admissions, was not shared or used locally and was only reviewed at the organisational level governance meeting held twice a year.
- The provider had not updated all policies and procedures to reflect changes in practice at the service. Some policies and procedures contradicted each other.
- The service did not yet have a fully comprehensive risk register that allowed staff to identify risk and manage it.
- The service did not have an updated fire risk assessment in place.

However:

- All clients undergoing detoxification had a comprehensive medical assessment.
- All clients' medical assessments were consistent and standardised.
- All clients had a comprehensive risk assessment and risk management plan in place before starting treatment.
- The provider's storage and administration of medicines had improved.
- The provider had installed new heat and fire detection systems and done remedial works to comply with the local fire service's enforcement.
- The provider had taken action to ensure that environmental risks were appropriately identified, managed and mitigated.

We did not review the breaches identified under Regulation 5, Fit and Proper Persons and Regulation 18, Safe Staffing during this inspection. These breaches are carried forward in this inspection report and will be reviewed at our next inspection.

The service voluntarily agreed to continue not to admit any clients for alcohol detoxification who had a history of alcohol withdrawal seizures and delirium tremens until the service is comprehensively inspected.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Residential substance misuse services		

Summary of findings

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No 4

Services we looked at:
Residential substance misuse services

Summary of this inspection

Background to No 4

No 4 is a three-bedded unit based in a mews house in Kensington. It is run by PROMIS clinics, which has two other services on the same street called No 11 and No 12. While the three locations are registered separately, they operate as one service with the same manager and the same staff covering all three locations. We completed one inspection which reviewed all three registered locations.

Clients in the three services use shared communal areas located at No 11, including a kitchen and a living room. The clinic room for the three services is also located at No 11. There are some therapy rooms, which are used by clients across the three locations, at No 12.

The service provides medically monitored alcohol and drug rehabilitation services including a psychological therapy programme. At the time of our inspection, there were no clients in residence at No 4. Since the last inspection in May 2019, the service had 31 admissions for detoxification, 29 for alcohol detoxification and two for benzodiazepines detoxification.

The service is registered to provide the following regulated activities:

- Accommodation for persons who require treatment for substance misuse
- Treatment for disease, disorder and illness.

No 4 was first registered with CQC in June 2016. We have inspected No 4 twice since 2016. All inspections of No 4 have been carried out simultaneously with an inspection of No 11 and No 12 (August 2017 and May 2019).

We undertook an unannounced inspection of No 4 in May 2019. This inspection identified concerns regarding safety and quality of the service which put clients at risk of harm. The service was rated as inadequate overall and was placed into special measures. Following this inspection, the service voluntarily agreed to not admit any clients for alcohol detoxification who had a history of alcohol withdrawal seizures and delirium tremens.

We also took enforcement action against the provider and issued warning notices in relation to regulation 15: Premises and Equipment. We required the provider to achieve compliance against the breaches detailed in the warning notice by 1 October 2019. We additionally issued requirement notices in relation to Regulation 5, Fit and Proper Persons, Regulation 12, Safe Care and Treatment and Regulation 18, Staffing.

We told the provider it must take the following actions to improve the service:

- The provider must ensure that health and safety, environmental risks and fire safety are managed to ensure that clients and staff are kept safe.
- The provider must ensure that all aspects of care and treatment for patients undergoing alcohol detoxification follow national guidance. This includes all clients having a comprehensive assessment, including physical health examination and mental health history, cognitive assessment and offer of blood borne virus screening, prior to commencing detoxification treatment.
- The provider must ensure that all clients have a comprehensive risk assessment and risk management plan in place prior to starting treatment.
- The provider must ensure that comprehensive and effective clinical audits and service audits are undertaken on a regular basis and follow up actions are taken when necessary.
- The provider must ensure that supervision records for all staff working at the service are maintained and that supervision sessions cover relevant quality and safety topics.
- The provider must ensure there is a clear framework detailing what must be discussed at each level of the organisation to ensure that essential information is shared with relevant directors and staff members. This may include a framework of regular meetings with standard agenda items.
- The provider must ensure that effective systems are in place to assess, monitor and improve the quality of service. This may include benchmarking so staff engaged in audits know the standards required.
- The provider must have a process in place to make robust assessments to meet the fit and proper persons regulation (FPPR).

This inspection in October 2019 focused on the providers progress in addressing breaches under Regulation 15,

Summary of this inspection

and Regulation 12. The inspection did not follow up on the breaches under Regulation 5 and Regulation 18. The service will be comprehensively inspected within six months of the publication of the May 2019 inspection report (9 August 2019), where the providers progress in addressing these breaches will be assessed. The breaches under Regulations 5 and 18 are therefore carried forward to the comprehensive inspection.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and one specialist professional advisor with a nursing background in the field of substance misuse.

Why we carried out this inspection

We inspected this service to check whether the provider had taken actions to improve following the inspection in May 2019. At this unannounced focused inspection, we reviewed aspects of the safe and well-led key questions to identify if the breaches outlined in relation to Regulation 12 and Regulation 15 had been met.

How we carried out this inspection

This inspection focused on whether the provider had made improvements in meeting the breaches identified under Regulations 12 and 15 from an earlier inspection in May 2019.

Before the inspection visit, we reviewed information that we held about the location. The inspection was unannounced, which meant the provider did not know we were coming.

During the inspection visit, the inspection team;

- visited the service and undertook an assessment of the quality of the environment and observed how staff were caring for clients
- spoke with the service manager
- spoke with four other staff
- carried out a specific check of the medication management procedures and medication administration records
- looked at policies, procedures and other documents relating to the running of the service.

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?

As this was a focused inspection we did not change the rating for safe. We saw that significant improvements had been made to ensure that clients received safe care and treatment.

- Significant progress had been made in addressing fire safety issues at the premises. The provider had installed an updated heat and fire detection system. Remedial building works relating to fire safety had been completed. Staff carried out regular checks on fire safety systems.
- Staff would complete a comprehensive assessment for each client before they started detoxification treatment. This included a physical health examination, mental health history and a cognitive assessment.
- Systems were in place to ensure clients' medical assessments were consistent and standardised. Prescribing doctors met face to face with clients before they started their detoxification.
- Comprehensive risk assessment and risk management plans were in place for each client before they started treatment.
- The provider's storage and administration of medicines had improved.

However;

- Whilst the service had made significant progress in addressing and improving fire safety at the service, they had not had a fire risk assessment completed since building work took place. This meant there could be risks associated with fire safety that the service was unaware of and did not have appropriate actions in place to manage or mitigate.

Are services well-led?

As this was a focused inspection we did not change the rating for well-led. We saw that whilst some improvements had been made, further work was needed to strengthen and embed governance systems.

- The service's governance processes were not yet fully embedded. It was not clear where responsibility for assurance lay. For example, what level of meeting issues were discussed and actioned at.
- Some of the provider's quality and safety data, for example data on staffing and admissions, was not shared or used locally and was only reviewed at the organisational level governance meeting held twice a year.

Summary of this inspection

- The service had not updated all of their policies and procedures to reflect changes in practice. Some policies and procedures contradicted each other.
- The service did not yet have a fully comprehensive risk register that allowed staff to identify risk and manage it.

However;

- The service had introduced regular team meetings and clinical managers meetings. They used consistent agenda items for these meetings and some of the agenda items from these meetings were consistent across the provider's twice a year organisation wide governance meeting.

Detailed findings from this inspection

Residential substance misuse services

Safe	
Well-led	

Are residential substance misuse services safe?

Safe and clean environment

At the previous inspection in May 2019, we found that clients were at risk because the provider was not appropriately identifying or managing risks associated fire safety. We were sufficiently concerned to ask the local fire service to make their own inspection. They attended the premises on 3 May 2019 and subsequently informed the provider of action required improve the premise's fire safety precautions.

During this inspection we found there had been some improvements. The provider had bought and had installed an updated heat and fire detection system. Areas which did not previously have smoke detectors were now appropriately covered, for example the kitchen area, lounge area and integral garage. A contract to service and maintain the system was in place. The contractor provided appropriate installation certificates.

The provider had disconnected the electric oven and gas supply to the kitchen to ensure a safe fire exit from the premise based on the advice of the local fire service. Now the kitchen area was only for making tea and coffee. Clients were able to prepare meals and snacks at No 11. Changes to the how the kitchen was used meant that a carbon monoxide monitor was no longer required in this area. The fire blanket in the kitchen was recently serviced.

The provider's new heat and fire detection system covered all the bedroom areas and replacement fire doors had been fitted.

Staff now recorded weekly checks of the fire alarm system in the fire log book. The service carried out a fire drill on the 6 July 2019 and documented this in the fire log book. Training records showed that staff had received fire evacuation training.

However, an updated fire risk assessment had not been completed. This meant there could be risks associated with fire safety that the service was unaware of and did not have appropriate actions in place to manage or mitigate. The provider said that a fire risk assessment was scheduled to be done by an appropriate contractor following a second visit by the local fire services.

Areas clients had access to were visibly clean, comfortable and well-maintained.

Safe staffing

The service had enough staff to meet the needs of the client group and could manage unforeseen shortages in staff. The service rarely used bank and agency staff. However, bank and agency staff were available to cover sickness, leave and any vacancies. All new staff received an induction to the service.

There was a registered nurse working at the service at all times. The staff team consisted of registered nurses, healthcare assistants, therapy staff, housekeeping and a chef. The service had a registered manager for the three services in London.

Medical cover for the service was contracted through a local GP practice. We spoke with one of the doctors and found that they had appropriate knowledge, skills and experience to work safely with the client group.

Assessing and managing risk to clients and staff

Assessment of risk

Systems were in place for staff to assess and manage risk to clients appropriately.

There were no clients receiving care or treatment at No 4 when we carried out our inspection. One client had received care and treatment at No 4 since our previous inspection in May 2019.

The provider had reviewed and strengthened their referral, assessment and admissions processes. Staff now completed a more robust four stage triage and assessment process before clients started detoxification treatment. This included a face to face assessment with the doctor prescribing them medicines. The first stage was done by the provider's central referrals team, who assessed all referrals for suitability. Then the provider's admissions

co-ordinator reviewed the referral. Next, nursing staff assessed the referred individuals onsite. Finally, the service doctor met with the client and completed a medical assessment. Staff used appropriate tools to measure dependency and withdrawal. For example, the Severity of Alcohol Dependence Questionnaire and the Clinical Institute Withdrawal Assessment for Alcohol. Staff told us that all clients would go through this process.

At the last inspection, we saw that staff did not always do a comprehensive medical assessment of clients, including a physical health assessment, before clients started treatment.

During this inspection we found that the provider had made improvements in this area. The service doctor would undertake and document physical health examinations prior to treatment commencing. Staff were aware that clients admitted for detoxification treatment should be assessed for respiratory issues and we saw this area included in assessment documents.

The service now assessed clients for neurological conditions as part of their assessment process. The medical assessment by the doctor now included a neurological examination and a Wernicke's assessment. In addition, the service's psychiatric consultant would review all clients after their initial assessment with the doctor. The psychiatric consultant would carry out a mental state examination to establish any underlying or presenting mental health condition. Staff we interviewed were aware of clients being assessed for cognitive conditions such as Wernicke's encephalopathy. Wernicke's encephalopathy is a neurological emergency resulting from thiamine deficiency and needs to be treated quickly.

Staff now included blood born viruses in the service's nursing and medical assessments.

The service had appropriate systems were in place to ensure that information from the clients GP was available to the service doctor in advance of their medical assessment.

The service had systems in place to ensure that clients received safe care and treatment that met their needs when they declined consent for the service to liaise with their GP. Staff said that information from the clients GP and/or other medical professionals was requested at the start of the assessment process. If a client declined to give consent for the service to contact their GP, the service doctor discussed this with the client during their assessment. If the client still declined, the service's doctor assessed whether or not they could safely treat the client and either admitted them or refused admission. Staff were aware of this process.

The service had arrangements were in place to ensure that clients could be prescribed oral thiamine and vitamin B12 supplements. The service doctor was able to prescribe pabrinex if the patient's history and presentation indicated its use.

Management of risk

Systems were in place for staff to manage risk to clients appropriately.

During this inspection we saw that appropriate systems and processes were now in place to support the assessment and management of individual client risk. Appropriate systems were in place to ensure that clients would receive regular physical health monitoring checks (blood pressure, respiratory rate and pulse) whilst they were undergoing detoxification.

As a result of the last inspection in May 2019, the service had voluntarily agreed not to admit any clients with prior history of seizures and/or delirium tremens. Staff we spoke to confirmed that the service had not admitted any clients with prior history of seizures and/or delirium tremens since that inspection. Medical and nursing staff stated that any history of seizures and/or delirium tremens would be raised at each point of assessment and included in the medical assessment form.

Medicines management

The service's storage and administration of medicines had improved. The service now had appropriate arrangements in place to securely store medicines and appropriately administer them.

The service had made improvements to some areas of its policies relating to medication and medicines management. The management and administration of medicines policy had been updated to remove out-of-date guidance. The policy now included a section on the disposal of medicines which included recording details such as the date of disposal/return to the pharmacy. It also included name and strength of medication, quantity being

disposed of, person for whom medication was prescribed or purchased, signature of the person disposing the medication and a witness signature for the disposal of any controlled drugs.

Safety notices were referred to in the current policy with details of how to communicate and record alerts, along with the actions staff should take.

However, the management and administration of medicines policy still did not cover the management of medicines for clients on leave. This meant that there may be a potential risk of unsafe practice if a client was taking medicines whilst on leave from the service.

The service's detoxification policy and protocol now referred to fixed prescribing regimens for detoxification in line with best practice guidance.

At the last inspection in May 2019, we found that the service had a Patient Group Direction (PGD) for the administration of buccal midazolam. Buccal midazolam is used to treat seizures. The service's PGD warned that staff should be prepared to assist with ventilation after the administration of buccal midazolam. However, the service did not have the equipment to assist clients with ventilation. In order to treat clients safely, the staff should have assessed all patients for respiratory issues on referral and made decisions about what medicines were appropriate. During this inspection, we saw that the service doctor assessed clients' respiratory system and respiratory rate as part of their medical assessment. However, we found that the PDG had not been updated to reflect current practice. When we raised this, the provider updated the PDG.

Are residential substance misuse services well-led?

Governance

At the previous inspection in May 2019, we found the governance systems and processes in the service were not effective and did not help to keep people safe. During this inspection we found that whilst there had been improvements, the service's governance processes were not yet fully embedded.

The provider's framework that assessed the quality and safety of the service and drove improvement was in its early stages. It still did not clearly identify where responsibility for assurance activities was located. For example, it did not clearly identify who was responsible for what, and what was discussed at each governance level. We were also told that some data gathered within the service, for example data on staffing and admissions, was not shared or used locally and was only reviewed at the organisational level governance meeting held twice a year. This meant that there was a risk that information and data relating to the quality and safety of the service was not shared with staff or used to drive improvement.

However, the service had started to conduct regular team meetings, alongside clinical managers meeting, and some of the agenda items from these meetings were consistent across the provider's twice a year organisation wide governance meeting.

The service had not fully updated all of the policies and procedures to reflect the changes in clinical practice to meet best practice guidance. For example, staff had not updated the policy and procedure relating to when a client withheld consent for staff to get their medical history from their GP. It did not include information that without the medical history, the final decision about admission was made by the service doctor.

Where guidance for staff was duplicated over several policies and procedures, some of these had been updated and others had not. This meant that contradictory guidance was available for staff. For example, the detoxification policy had been updated to state that clients must be assessed face to face by the service doctor before starting treatment. The admissions protocol had not been updated to include this information. There was therefore a risk that clinical practice may not be safe as staff were following out-of-date guidance. This was a particular risk on occasions when the service was dependent upon agency staff to care for clients.

Some policies and procedures had not been updated, for example the management and administration of medicines policy did not include the arrangements for obtaining and administering medicines for clients on leave.

However, we did see some improvements in relation to governance during this inspection. The service's detoxification policy and protocol had been updated to state that drug regimens should be adjusted accordingly

for people with established liver disease. The detoxification policy and protocol had also been updated to include an overview of Wernicke's encephalopathy and the use of pabrinex.

The service now had infection control audit and an environmental risk assessment in place. The premises infection control audit and environmental risk assessment were comprehensive and identified issues and recorded actions to address any issues. We saw evidence that staff had completed necessary actions. The service manager told us that the infection control audit and environment risk register would be updated on a quarterly base.

Staff team meetings had now taken place every two weeks since May 2019, were recorded and used a standard agenda.

Management of risk, issues and performance

At the previous inspection in May 2019 we found it was not clear how the service managed service level risk and other issues. During this inspection we saw improvements, but further work was needed to ensure that systems to identify, manage and mitigate risks to the service were robust and effective.

The service did not have a fully comprehensive risk register to identify and manage service level risks. Examples of risks are the breaches identified in our previous inspection. The provider had developed a 'preliminary' risk register, however this was in its early stages and focused on environmental and health and safety issues. It did not include other risks relating to the delivery of the service. We were told that there were plans to expand to include risks to the delivery of the service. Without a comprehensive risk register, risks to service delivery may not be not appropriately identified, monitored and mitigated.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all the service's policies, protocol and procedures documentation are updated to reflect current practice in the service. Regulation 17(1)(2)(a)(b)(f).
- The provider must ensure that a risk register for the service is implemented and regularly updated to ensure that appropriate measures are in place to mitigate any identified risks to the provision of services. Regulation 17(1)(2)(a)(b)(f).
- The provider must ensure that a fire risk assessment is completed and any identified actions are implemented without delay. Regulation 12(1)(2)(d).
- The provider must ensure there is a clear governance framework in place to ensure the quality and safety of the service. This may include a framework of assurance activities, who are responsible for assurance activities, which meetings these are discussed at, and how these feed into an overall assurance framework for the service from frontline staff to the board. Regulation 17(1)(2)(a)(b)(f).
- The provider must ensure that supervision records for all staff working at the service are maintained and that supervision sessions cover relevant quality and safety topics. Regulation 18(1)(2)(a) (May 2019 inspection).
- The provider must have a process in place to make robust assessments to meet the fit and proper persons regulation (FPPR). Regulation 5(1)(2)(5) (May 2019 inspection).

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
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors The provider did not have a proper process to make robust assessments to meet the fit and proper persons regulation (FPPR). The provider was unable to show us that appropriate fit and proper persons checks were carried out to make sure that directors are suitable for their role. This was a breach of Regulation 5(1)(2)(5) (May 2019 inspection).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not have an up to date fire risk assessment. The provider did not ensure that a fire risk assessment was completed and any identified actions are implemented without delay. This was a breach of Regulation 12(1)(2)(d).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that all the service's policies, protocol and procedures documentation reflected current practice in the service

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	The service did not have a comprehensive risk register. The provider did not ensure that the service implemented and regularly updated a risk register to ensure that appropriate measures were in place to mitigate any identified risks to the provision of services. The service did not have a clear governance framework in place to indicated where responsibility for assurance activities was located. This was a breach of Regulation 17(1)(2)(a)(b)(f).
	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff supervision records were not completed or available and there was no assurance that relevant topics were covered, such as those related to quality and safety. This was a breach of Regulation 18(1)(2)(a) (May 2019 inspection).