No 12

Quality Report

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

Overall summary

Amah limited is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury
- Accommodation for persons who require treatment for substance misuse

The service has a registered manager in place.

Amah limited provided treatment and accommodation for people with substance misuse problems, including rehabilitation and alcohol and opiate detoxification.

This inspection consisted of two visits, one on the 27 October and one on 24 November 2015.

During the inspection visit on the 27 October 2015 serious concerns were identified about the care and treatment of patients going through alcohol and opiate detoxification. There were a lack of staff that held the appropriate qualifications, competence, skills and experience to provide care, treatment and support patients safely. Staff were not trained in completing physical health checks and monitoring deteriorating health. Staff had not completed mandatory training courses, this included safeguarding vulnerable adults and children at risk, assessing needs and the Mental Capacity Act.

Medicines management was poor and unsafe. Medication was being written on medicine administration charts and was not being signed by the prescribing doctor. There were no systems in place to check this was being completed safely. A patient was prescribed medication via email without a medical assessment. Medicines prescribed as required had no maximum daily doses recorded in the records. Patients could potentially be administered more than the maximum permitted daily dose.

Risk assessments and risk management plans were limited in length and not comprehensive. For patients who were suicidal, the risk was not documented in detail for how this would be managed during the admission. None of the care plans included regular monitoring of physical health using a recognised tool. The only physical health monitoring being completed was on admission which included blood pressure, pulse and weight. Staff had no training to carry out physical health observations.

As a result of the serious safety concerns identified we issued the provider with a letter of intent to use Section 31 of the Health and Social Care Act 2008 notice, on 9 November 2015. In response to this, the provider voluntarily stopped admitting patients to the service.

During the second inspection visit on 24 November 2015, Amah limited had made improvements and changes in response to our concerns. Comprehensive risk assessments and risk management plans had been reviewed. The management of medicines had significantly improved and an external company

Summary of findings

employed to regularly check and audit medicines. All staff had completed required mandatory training for their roles and responsibilities. A detox policy and procedure had been implemented to describe responsibilities of staff. The policy included care during detox and the requirements of tele prescribing. However, the policy was not comprehensive and required further improvements.

Following the second inspection the decision was taken to allow Amah limited to start readmitting patients again. The provider understood the areas that required further improvements.

Summary of findings

Contents

Summary of this inspection

Page

Background to No 12 4

Our inspection team 4

Why we carried out this inspection 4

How we carried out this inspection 4

What people who use the service say 5

The five questions we ask about services and what we found 6

Detailed findings from this inspection

Mental Health Act responsibilities 7

Mental Capacity Act and Deprivation of Liberty Safeguards 7

Outstanding practice 11

Areas for improvement 11

Action we have told the provider to take 12

Summary of this inspection

Background to No 12

No.12 is provided by Amah Limited. This service works very closely with No.11 which is provided by Aissa Limited. They are all part of the overarching provider called PROMIS.

The service provides a medically supervised alcohol and drug rehabilitation facility. The service offers psychological therapy programme along with medical input. The average length of stay is approximately four weeks but this can be longer if required. No.12 can accommodate up to three patients at one time. Patients use the providers other location for accommodation and treatment. These services are registered separately. On the day of inspection there were two patients admitted to the service. Four patients from the providers other location attended the service for part of their therapy programme.

No.12 had registered in 2012 and had been inspected in July 2013 against fundamental standards. This report was published in September 2013.

Our inspection team

This inspection consisted of two visits on the 27 October and 24 November 2015.

The team that inspected the service on the 27 October 2015 comprised of one inspector, two inspection managers and a specialist advisor, specialising in substance misuse services.

The team that conducted the second inspection visit on 24 November 2015 consisted of one inspection manager and one inspector.

Why we carried out this inspection

We carried out an unannounced inspection to No.11 due to concerns raised during a routine inspection of a separate location which is owned by the same parent provider, PROMIS.

This was a responsive inspection and specifically focused on the safe care and treatment of service-users at No.12. The service was working closely with No.11; this service was also inspected on the same day.

We carried out a second visit as part of the same inspection on 24 November 2015 to monitor how the concerns were being addressed by the provider. This visit was also to assess whether the provider could start accepting admissions.

How we carried out this inspection

To fully understand the experience of people who use services and fully investigate the concerns that were raised at a separate location, this inspection only focused on the following question:

- Is it safe?

Before the inspection visit, we liaised with our inspection colleagues and reviewed information that we held about the location.

This inspection consisted of two visits.

During the first inspection visit on the 27 October 2015, the inspection team:

Summary of this inspection

- visited No.11 and looked at the quality and safety of the environment
- spoke with one patient who was using the service;
- spoke with the registered manager and the unit managers
- spoke with two members of staff
- looked at four care and treatment records of patients
- carried out a specific check of the medication management
- looked at medicines management policy and other documents relating to the running of the service.

During the second inspection visit on 24 November 2015, the inspection team:

- spoke with two managers
- looked at one care and treatment records of patients
- carried out a specific check of medication management
- looked at training records, the detox policy and other documents relating to the running of the service.

What people who use the service say

Patients were mostly positive about the service. Patients said they felt respected and that they felt they were receiving high quality care and advice. The patients felt that the staff were very professional and friendly. Patients told us the food was very good and that there was a wide variety of food options that was nutritious and healthy.

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?

At the first inspection visit on the 27 October 2015 it was found that staff did not carry out regular physical health checks on patients undergoing alcohol detoxification in order to identify withdrawal symptoms and any deterioration in physical health. Most staff did not have sufficient training to be able to provide safe care to patients undergoing assisted alcohol withdrawal or opiate detoxification. Mandatory training was limited and did not cover all responsibilities staff undertook. Training was not being regularly updated or refreshed. Staff were being asked to complete withdrawal scale without the appropriate training, skills and knowledge.

The risk assessments and risk management plans were limited and not comprehensive. This was also reflected in the care planning. The care plans were vague with no detail of how goals would be achieved.

There were no formal observational records found for patients. Records should detail how often a patient would be observed and the activity of the patient during the observation. General feedback about the patients was found in an electronic handover document.

The provider had not completed full employment checks prior to staff working at the service. This included a lack of references and criminal history and backgrounds checks. There was no detoxification protocol in place. The provider was found to not be notifying CQC with statutory notifications of incidents that have occurred within the service.

At the second inspection visit on the 24 November 2015 it was found a number of actions had taken place. The provider had reviewed care plans and risk assessments, medicines management, physical health checks and employment checks. These areas had all significantly improved. The provider was recording patient observations formally. A new, revised detoxification policy and procedure had been implemented; however, this required further developments.

Detailed findings from this inspection

Mental Health Act responsibilities

This area was not inspected. We did not undertake a comprehensive review of this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

This area was not inspected. We did not undertake a comprehensive review of this service.

Substance misuse/detoxification

Safe

Are substance misuse/detoxification services safe?

This inspection was a focused inspection to follow up identified concerns. We did not undertake a comprehensive review of the service.

Safe and clean ward environment

- The service was located in a townhouse, split into 2 floors and was providing care and treatment to two, male service-users. Staff were not able to easily observe patients at all times. The layout of the building was such that lounge areas, bedrooms and therapy rooms were located on separate floors which meant that staff did not have clear lines of sight. The environment was clean, free from clutter and had well-maintained furniture. However, there was an odour of car fumes coming from the car garage below. This smell was strong in the stair/ hallway and in the communal kitchen.

Safe staffing

- The service operated 24 hours a day, 7 days a week**.** The multidisciplinary team (MDT) included two housekeepers, three healthcare assistants (HCAs), two clinical psychologists, one art psychotherapist, one neuro-linguistic programmer (NLP), one cognitive behavioural therapist (CBT), one GP and one consultant. Two HCAs were employed during the day and one HCA during the night. The night shift hours were 6pm to 9am. At the first inspection visit on the 27 October 2015 there were no full-time registered nurses working at the service. A nurse working at other PROMIS services would visit during the week but there were no set hours. Other staff members covered staff sickness internally; however, management told us this rarely happened.
- In response to us raising the concerns about safe staffing, the provider reviewed its staff establishment. At our second visit on 24 November we found that a permanent nurse had been employed for 12 hours a day, seven days a week. This did not include during the night. The service provided one HCA during the night which covered a 15 hour shift. After our visit, the provider had increased the nursing input to 24 hours a day, seven days a week.
- A local GP could be contacted for advice and support as well to conduct assessments on admission and prescribe medication. A visiting psychiatric consultant would also review patients, recommend treatments to the GP but did not prescribe medication. During the night there were medical doctors that could be contacted by telephone if required or in an emergency an ambulance would be called.
- In response to us raising the concern, the provider reviewed its processes for assessments on admission. The service told us on 24 November 2015 that nurses were now undertaking initial assessments with patients. This included assessing individual needs, risk assessments, physical health assessment and gaining medical history details. Qualified nurses were responsible for the further monitoring of patients physical health and were supported by the doctors. The nurses were using early warning scores to assess physical health results. The provider did not yet have a policy in place for this; therefore there was no formal escalation procedure to raise concerns. The manager told us that staff were aware of how to respond in an emergency but acknowledged this was an area of ongoing work.
- At the initial inspection visit on the 27 October mandatory training was limited and did not cover all responsibilities staff undertook. There was no set timescales to update or refresh training. Staff did not receive training for completing physical health monitoring and recognising deteriorating health conditions. The registered manager confirmed that first aid training had been provided to staff. One out of five staff members were trained in first aid awareness. This was not in accordance with National Institute for Health and Care Excellence (NICE) guidance: Alcohol-use disorders: diagnosis and management of physical complications, assessment and monitoring (2010) or equivalent.
- The manager told us HCAs received training by Social Care TV training, which was an online training resource for administering medication. Care records showed that a member of staff was asked to complete withdrawal assessments without the appropriate training. All members of staff employed as HCAs had not received

training in assessing needs, risk assessment and care planning. Only five out of sixteen members of staff had received online training in safeguarding adults at risk. Training records showed that four out of five therapists are not trained in care planning.

- Staff training was not up to date for record keeping, moving and handling, infection control, Mental Capacity Act, assessing needs and safeguarding vulnerable adults and children. Staff had not received specialist training in how to monitor patients undergoing detoxification and how to manage this safely.
- In response to us raising the concern, the provider reviewed the training that it provided to staff. During our second visit on 24 November 2015 we found the mandatory training had significantly improved in all areas. All staff had been trained in safeguarding of vulnerable adults and children, care planning, Mental Capacity Act and moving and handling. Qualified nurses were going to be training HCAs in how to use recognised withdrawal tools.
- At the first inspection visit on the 27 October the provider had not carried out the appropriate checks on staff members to ensure they were suitable for working with people who were potentially vulnerable. Four out of 16 employment records reviewed did not include references. One member of staff was awaiting references to be returned to the provider but was allowed to commence employment without this.
- Criminal background checks had been carried out with Disclosure and Barring Service (DBS) for seven staff members. However, nine members of staff did not have a current DBS certificate completed and were working at the service.
- At the second visit on 24 November 2015 DBS checks had been completed for all staff.

Assessing and Managing risk to patients and staff

- At the first inspection visit on the 27 October the service provided alcohol and opiate detoxification for patients but this was not being managed in a safe way. We had asked the manager for specific policies or protocols in place addressing the needs of patients undergoing detoxification form but we did not receive this.
- In response to us raising the concern, the provider reviewed its policies for completing detoxification for patients. At our second visit on 24 November 2015, the provider had put in place a 'Detox policy and procedure' 2015. This policy included what action was needed pre-admission, during admission, the responsibilities of qualified and non-qualified staff, tele prescribing and the monitoring of patients during detoxification. The provider was introducing the use of Skype assessments for patients who live aboard. The policy was not comprehensive and lacked important details, including a clear procedure for tele-prescribing and completing assessments. However, the provider had reviewed and amended the policy after the inspection.
- At the first inspection visit on the 27 October risk assessments and risk management plans were limited in length and not comprehensive in the two records reviewed. For patients who were suicidal, the risk was not documented in detail to show how the risk would be managed during admission. Staff had not produced comprehensive and detailed care plans. The care plans showed one worded, vague answers. For example, a goal for a patient was to achieve more stability in mood, the steps to the goal was to 'attend sessions'. The care plan did not elaborate further. Another example of this was a record that said a patient's goal was 'Hypnotising'. This was the only word recorded in the 'physical' part of the plan. There was no further elaboration of what this goal meant or steps in order to achieve the goal. The other parts of the care plan were blank.
- At the first inspection visit on the 27 October care plans were not ensuring and promoting the safety of patients. For example, a patient's goal was to complete medical detoxification and develop alternative strategies. The steps to achieve this goal said 'adhere to Doctor X recommendations'. There were no recommendations documented. The steps did not explain how the goal would be achieved. Overall the care plans were not specific, measurable, achievable, relevant and timely (SMART) goals. Care plans reviewed were not in accordance with guidance for detoxification as detailed in the National Treatment Agency (NTA) Care Planning guide 2006 or equivalent.
- In response to our concern, the provider reviewed its care plans. During our second visit on 24 November 2015 we found, risk assessments and care plans for two patients were reviewed. Records had been completed sufficiently and were appropriately detailed.
- At the first inspection visit on the 27 October there were no formal observational records found for service-users. The manager confirmed that observations were not documented once completed. This detail would be

included in a handover style email to other members of staff highlighting the patients' activity. The service did not have verbal handovers, this was completed electronically.

- In response to our concern, the provider reviewed how it recorded observations. During our visit on 24 November 2015, HCAs were updating a formal observation log every two hours to describe patient activity.

Track record on safety

- There had been five incidents reported since July 2015 and two safeguarding referrals had been completed in the month of October 2015.

Reporting incidents and learning from when things go wrong

- At the first inspection visit on the 27 October it was found that the CQC had not been receiving statutory notifications from the provider. This was confirmed by the manager that notifications were not being completed.
- There was a discrepancy in the reporting of incidents as the human resources data showed five incidents had been reported since July 2015. The accident book showed six incidents had occurred since July 2014. The incidents included slips, falls, a medicine issue and a police incident.
- On 24 November 2015 the provider confirmed that they now had a clear understanding of the requirement to inform the CQC of statutory notifications.
- A separate incident book showed three incidents had occurred since January 2015 which included a medicines incident and an injury.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is a comprehensive protocol in place which covers the monitoring of patients physical health and the escalation process.

Action the provider SHOULD take to improve

- The provider should ensure that statutory notifications continue to be reported appropriately to the CQC as per guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a comprehensive and detailed protocol or policy in place to ensure safe care and treatment. This was a breach of regulation 17(1) (2) (a) (b).