ADHD 360 - admin centre

Inspection report

4 Woodmans Yard
Horncastle
LN9 6RA
Tel: [redacted]
www.adhd-360.com

Date of inspection visit: 17 November 2020
Date of publication: 22/01/2021

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	**Requires Improvement**
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Requires Improvement**

Overall summary

This service is rated as Requires improvement overall. Choose a rating

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

ADHD360 admin centre is an independent diagnostic and treatment service for children and adults with attention deficit attention disorder. Clinics are held in various locations across England.

Why we did this inspection

ADHD360 admin centre was registered with the CQC in April 2019. The service has never been inspected and therefore does not have a rating. We received intelligence from several sources which raised concerns about the running and prescribing practices at ADHD360.

What we found

Managers did not have a specific incident reporting system. We found examples of incidents that had not been reported. Although clinical staff recognised incidents and reported them to the registered manager by e mail.

Managers did not have records of staff compliance with mandatory training. Staff reported they were up to date with mandatory training. Managers did not have a specific emergency planning policy or procedure in place.

Managers did not manage complaints effectively. Whilst a complaints log was in place it did not provide a detailed description of the complaint, the investigating officer, how a resolution had been reached, how learning had been shared or how duty of candour requirements had been met.

However:

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised holistic and recovery oriented.

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care and treatment.

Overall summary

The service was easy to access and used technology to ensure patients were seen in a timely manner. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.

What people told us

Patients told us they were very well informed about the possible side effects of their medication and that staff were very kind and helpful. Two patients told us that they were unhappy that they had been assured there would be a shared care arrangement in place, however this was not the case. One patient said that staff had been rude to them.

Carers told us the service was very responsive and called them back very quickly if they had a problem and that the service was a “lifeline”.

Staff told us they were very proud and loved their job, they were particularly impressed with the amount of development and training opportunities.

Our key findings were:

We rated ADHD360 admin centre as requires improvement because:

Managers did not have a specific incident reporting system. We found examples of incidents that had not been reported, although clinical staff recognised incidents and reported them to the registered manager by e mail.

During the inspection, managers did not have records of staff’s compliance with mandatory training. Managers told us that the online system used for staff records had crashed and the data was not available, and they did not hold local records.

Managers did not have a specific emergency planning policy or procedure in place.

Managers did not manage complaints effectively. Whilst a complaints log was in place it did not provide a detailed description of the complaint, the investigating officer, how a resolution had been reached, how learning had been shared or how duty of candour requirements had been met.

However:

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised holistic and recovery oriented.

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care and treatment.

The service was easy to access and used technology to ensure patients were seen in a timely manner. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.

Overall summary

Action the provider MUST take is necessary to comply with its legal obligations

- The provider must ensure they are in receipt of accurate physical health measurement prior to prescribing medication. The provider must ensure ligature assessments are undertaken in locations where patients are seen. Reg 12 – (2) (f) Physical Health Monitoring. (2) (a) (b) Assessing and mitigating risks to the health and safety of people using the services.

- The provider must ensure there are robust governance systems in place including, complaints procedure and oversight,duty of candour requirements, incident reporting, recording of clinical supervision, actions from audits and data breaches. Reg 17 (1) (2) (a) (b)(c)(e)(f)– Governance

The provider should take action to avoid breaching a regulation in future

- The provider should consider how they have up to date records of mandatory training compliance.
- The provider should consider clinicians recording their rationale for deviating from national prescribing guidance in care records.
- The provider should consider if and how the parents of children referred to the service have a mental health assessment as per national guidance.

Dr Kevin Cleary
Deputy Chief Inspector, Hospitals Director, mental health lead

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a CQC Inspection Manager, a hospitals mental health inspector, access to a specialist advisor and an expert by experience.

Background to ADHD 360 - admin centre

ADHD360 admin centre was registered with the CQC in April 2019. It is an independent clinic which diagnoses and treats children and adults with ADHD.

How we inspected this service

This was an unannounced comprehensive inspection looking at key lines of enquiry in the safe, effective, caring, responsive and well led domains.

Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, which was compliant with all Covid 19 government and Care Quality Commission guidelines, the team:

- visited the admin hub where we spoke to staff and reviewed care records.
- spoke with four patients and four carers of patients over the telephone.
- spoke with three other members of staff over the telephone: including a doctor and two nurses.
- spoke with the registered manager.
- looked at nine care and treatment records.
- looked at a range of policies, procedures and other documents r of patients.s elating to the running of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

We rated safe as Requires improvement because:

The risk assessments of the clinical environmental were patients were seen did not include a ligature risk assessment. Managers told us that patients were accompanied at all times; however, this did not include toilet areas.

Managers told us they supplied equipment for all patients to take blood pressure reading prior to commencing treatment, however, we were informed this only applied to NHS patients. This meant the provider could not be assured the measurement submitted by private patients was accurate.

Managers did not have a specific incident reporting system. We found examples of incidents that had not been reported. Although clinical staff recognised incidents and reported them to the registered manager by e mail.

During the inspection managers did not have records of staff's compliance with mandatory training. Managers told us that the online system used for staff records had crashed and the data was not available.

Staff did not always document the rationale in patient records when they had deviated from national prescribing guidance.

However:

Staff carried personal alarms which were checked on a regular basis.

The service had enough staff, who knew the patients. The number of patients on the caseload of the individual members of staff, was not too high to prevent staff from giving each patient the time they needed.

Staff assessed and managed risks to patients and themselves.

Staff understood how to protect patients 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 kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

The service used systems and processes to safely prescribe, administer and record medicines.

Are services effective?

We rated effective as Good because:

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs, were personalised holistic and recovery oriented.

Staff used recognised rating scales to assess and record severity and outcomes.

Staff had a range of skills needed to provide high quality care. We saw evidence that clinical oversight and scrutiny was taking place. Staff told us they were having regular clinical supervision however this was in a variety of ways and not consistently recorded.

Managers provided an induction programme for new staff.

Staff supported each other to make sure patients had no gaps in their care. We received positive feedback in regard to relationships between clinical staff and stakeholders.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Clinicians had a good understanding of Gillick competence.

However:Substantive staff had not had an annual appraisal. However, we acknowledge that the service had only had substantive staff in post since November 2020.

Whilst staff provided treatment for the patients based on national guidance and best practice, they did not complete a mental health assessment of the parents of children before commencing treatment as per national guidance.

Are services caring?

We spoke with eight patients and carers using the service, seven gave positive and one gave negative feedback.

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care and treatment.

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to support when needed.

Staff informed and involved families and carers appropriately.

Are services responsive to people's needs?

We rated responsive as Good because:

The service did not have a waiting list.

The service was easy to access and used technology to ensure patients were seen in a timely manner. The provider's referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients promptly. Staff followed up patients who missed appointments.

The service met the needs of all patients including those with a protected characteristic. Staff helped patients to access information and advice on the company website.

However:

Whilst the service had a complaints policy and procedure this did not contain the requirements in relation to duty of candour. Managers held a complaints log which did not provide a detailed description of the complaint, who had investigated the complaint, how a resolution had been reached, or how learning had been shared.

Are services well-led?

We rated well-led as Requires improvement because:

Our findings from the other key questions demonstrated that governance processes did not operate effectively.

Managers did not have a specific emergency planning policy in place. Managers failed to report incidents or keep internal up to date records of staff training.

Managers did not manage complaints effectively. Whilst a complaints log was in place it did not provide a detailed description of the complaint, the investigating officer, how a resolution had been reached, how learning had been shared or how duty of candour requirements had been met.

Managers did not action the outcomes of audits. There was an audit which was not dated and identified an issue where clinicians were not aware who was prescribing for a patient, this posed a clinical risk.

Managers did not have a specific incident reporting system. We found examples of incidents that had not been reported. Although clinical staff recognised incidents and reported them to the registered manager by e mail.

The registered manager did not fully understand their role to meet regulatory requirements, they did not understand their legal responsibilities' in regard to data protection and we were aware that the service had moved location however we had not been formally notified of this. This has since been rectified.

We were told the service had a culture that encouraged openness and honesty. We heard on inspection animated conversations with raised voices. We were concerned that a raised voice may lead to colleagues not voicing their views and opinions that could discourage an open and honest culture. This was evident when we reviewed CQC local intelligence. Some patients felt that when they raised concerns they were not listened to and due to this disengaged with the provider at the early stages of a complaint investigation.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have accurate physical health measurements prior to prescribing medication. The provider did not ensure ligature assessments were undertaken in locations where patients are seen.** **This was a breach of Regulation 12 HSCA Regulations 2014 Safe care and treatment (2) (f) Physical Health Monitoring. (2) (a) (b) Assessing and mitigating risks to the health and safety of people using the services.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have robust governance systems in place including, complaints procedure and oversight, duty of candour requirements, incident reporting, recording of clinical supervision, actions from audits and data breaches.** **This was a breach of Regulation 17 HSCA Regulations 2014 Good governance (1) (2) (a) (b)(c)(e)(f)**