Oxford ADHD Centre Ltd

Oxford ADHD Centre

Inspection report

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Overall summary

In November 2017 we undertook an announced comprehensive inspection at Oxford ADHD Centre. We found the service was providing effective, caring, responsive and well-led services but there were improvements required in providing safe services. Following the inspection we issued a requirement notice.

We carried out an announced focussed follow up inspection on 21 March 2018 to check whether the required improvements had been made. We found necessary changes had been made to ensure the service was providing safe services.

The report from the November 2017 inspection can be found by selecting the 'all reports' link for Oxford ADHD Centre on our website at www.cqc.org.uk.

Our key findings were:

- Risks associated with the provision of services were well managed.
- The potential risks posed by medical emergencies had been assessed and action taken to ensure staff were prepared for a medical emergency.
- Prescribing was undertaken safely, including the process for initialising patients on medicines.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

- The provider identified, assessed and mitigated risks to patients.
- The potential medical emergencies which may occur and processes to manage these were identified and planned for.
- The process for identifying patients had been amended at referral stage to ensure safe prescribing took place.

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Detailed findings

Background to this inspection

We inspected Oxford ADHD Centre on 21 March 2018. An inspector undertook the inspection.

We looked at records related to patient assessments and the provision of care and treatment. We also reviewed documentation related to the management of the service.

Are services safe?

Our findings

We found that this service was providing safe care in accordance with the relevant regulations.

At the previous inspection in November 2017 we found risks associated with potential medical emergencies were not considered and acted on. The process for issuing prescriptions was not fully risk assessed and we identified concerns with the process.

At this inspection we found the risks we previously identified had been acted on and the provider was now meeting regulations.

Risks to patients

The service had implemented a protocol for medical emergencies. This included minor and major incidents. The protocol instructed staff on the location of the automatic external defibrillator (AED) (an AED is an electronic device that can be used to attempt life saving treatment in the event of a cardiac arrest) and when 999 should be called. A sign had been put in place to inform anyone who needed to access the AED that it was at the front of the building.

Safe and appropriate use of medicines

The process for patients accessing treatment had been amended to include their NHS numbers and referral from their GP. This ensured the provider had verified patients' identification and when any medicines were prescribed, the potential for any misuse had been minimised.