Learning Assessment and Neurocare Centre Limited

LANCuk Heywood

Inspection report

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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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- The registered manager had not taken sufficient action to remedy the concerns we raised at the last inspection. Patient records were not current, complete and contemporaneous and staff were not receiving supervision in line with the supervision policy.
- Staff did not assess and managed risk well. Risk was not considered and recorded at each appointment. There was no oversight of incidents within the service.
- The service did not have robust systems and processes in place for managing prescriptions.
- Staff records did not include all required documentation and checks.
- We did not find sufficient arrangements in place for the provider to determine the quality of the service provided and make improvements.
- The service was not well led, and the governance processes did not ensure that procedures relating to the work of the service ran smoothly.

However:

- Following the last inspection, patient records now included documentation and responses to complaints patients had raised.

As a result of this inspection, we used our enforcement powers to serve a Warning Notice to the provider under section 29 of the Health and Social Care Act 2008. This was served for failing to comply with Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance.

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community mental health services for people with a learning disability or autism	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to LANCuk Heywood

LANCuk (Learning Assessment and Neurocare Centre) provides assessment and treatment for both children and adults for attention deficit hyperactivity disorder and autism. Most of the staff working for LANCuk were self-employed on a sessional basis. The majority of staff had other substantive roles, mostly within NHS trusts.

LANCuk employed the director and administration staff.

LANCuk has been registered with CQC since 19 October 2017 to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury.

The service accepts private referrals for children and adults and is commissioned by the NHS to provide assessments and diagnostics for people living in Oldham, Rochdale and Bury.

The service had expanded and at the time of the inspection had the following additional NHS funded contracts:

- A contract to assess people for attention deficit hyperactivity disorder and prescribe and titrate medicines for attention deficit hyperactivity disorder in Wigan, Halton and Knowsley.
- Assessments for autism for children in Stockport.
- Assessments for attention deficit hyperactivity disorder for children in Tameside and Glossop.

A contract had also been agreed with Greater Manchester to provide autism and attention deficit hyperactivity disorder assessments which was due to start in November 2021.

The base in Heywood is where all the NHS patients are seen. LANCuk rent facilities in Wilmslow and London for their private patients. All administration takes place from the Heywood base.

There was a registered manager in post at the time of the inspection

We last inspected the service in July 2019. The service was rated requires improvement overall with ratings of requires improvement for safe and responsive and good for effective, caring and well led. We issued two requirement notices for Regulation 18 staffing in relation to supervision and Regulation 12 safe care and treatment in relation to consideration of risk for each patient.

What people who use the service say

Prior to the inspection we received information of concern from five patients regarding their experience of prescribing of medicines. They had received prescriptions for the wrong medicines and their prescriptions were late causing withdrawal symptoms for one and a mental health crisis for another. They had raised their concerns with the manager of the service and were concerned and disappointed at the response they received. There had also been difficulties contacting the service via phone. People left messages and did not receive a response.

Summary of this inspection

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

- Visited the service.
- Toured the service and clinic room.
- Received feedback from commissioners.
- Spoke with four staff including administrators and a non medical prescriber.
- Spoke with the registered manager.
- Looked at 13 care and treatment records of people.
- Looked at a range of policies, procedures and other documents relating to the running of the service including the repeat prescribing process.

This inspection was unannounced and focused in response to concerns raised. The inspection focused on the safe and well led key questions.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that there is an incident reporting and investigation process in place that staff understand and follow. (Regulation 12 (1))
- The service must ensure that risk is considered within each appointment and recorded within the records. (Regulation 12(1))
- The service must ensure there is an accurate, complete and contemporaneous record in respect of each patient including contact made by the patient and summaries of appointments. (Regulation 17 (1) (2) (c))
- The service must ensure that clinicians have access to the information they require and are able to add information to the clinical recording system in a timely manner. (Regulation (17) (1) (2) (c))
- The service must ensure they meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for staff records. (Regulation 17 (1) (2) (d))
- The service must ensure they have oversight of incidents to monitor and improve the quality and safety of the services provided. (Regulation 17 (1) (2) (a))
- The service must ensure there is oversight of safe prescribing of medicines, including repeat prescriptions, with protocols in place with staff expectations. (Regulation 12(1))
- The service must ensure staff receive regular supervision and the supervision policy is followed. (Regulation 17 (1) (2) (a))

Summary of this inspection

Action the service SHOULD take to improve:

- The service should ensure that they review the policies and procedures to include a date of creation and review.
- The service should ensure the additional staff are inducted to their role, understand their role and have access to the patient records.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community mental health services for people with a learning disability or autism	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Community mental health services for people with a learning disability or autism

Inadequate

Safe	Inadequate
Well-led	Inadequate

Are Community mental health services for people with a learning disability or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

All clinic rooms had the necessary equipment for patients to have thorough physical examinations. This included height measure and scales.

All areas were clean, well maintained, well furnished and fit for purpose. The landlord of the building coordinated the cleaning of the premises. Staff had access to antibacterial wipes to clean the equipment in-between use.

Staff followed infection control guidelines, including handwashing. We observed staff wearing masks and PPE disposal bins were in use.

Staff made sure equipment was well maintained, clean and in working order. Records showed the equipment had been calibrated.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. Staff did not monitor patients on waiting lists to detect and respond to increases in level of risk.

Assessment of patient risk

Staff did not complete risk assessments for each patient. At the last inspection in July 2019 we issued a requirement notice that staff must consider risk at each appointment with patients. We reviewed eight care records focusing on risk and found that in three of the records there was no consideration of risk.

Staff did not use a recognised risk assessment tool. The registered manager told us that they did not use any templates for the appointments with patients, which meant staff did not routinely record if they had considered risk as part of the appointment.

Management of patient risk

Staff did not continually monitor patients on waiting lists for changes in their level of risk. We reviewed the waiting list documentation for the Rochdale, Oldham and Bury contract as that service had been in place the longest and at the last inspection patients had been waiting over a year for appointments. When we reviewed the document it looked like

there were patients waiting for an appointment from 2018 however, the registered manager confirmed the spread sheet was not up to date and several patients had been offered appointments or had been discharged, although the spread sheet that the administrator was using to book appointments from did not reflect this. This meant there was not an accurate record of patients waiting to access the service.

The clinical leads reviewed the waiting list every three months. The staff capacity within the service had expanded which meant patients could be seen sooner. Records showed that at the end of March 2021 there was 277 patients waiting for their first appointment with the Rochdale, Oldham and Bury contract.

During COVID19 the service was offering welfare calls to patients and continued to offer a smaller number of welfare calls at the time of inspection.

Staff access to essential information

Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date and easily available to all staff providing care.

Patient notes were not comprehensive, and all staff could not access them easily. The service used two systems for patient records. The electronic patient record which included patient contact details and appointments was only accessible to the administrators, registered manager, clinical leads and one non-medical prescriber. This meant staff could not access details of all contact with the service and could not add notes to the system.

Patients also had individual electronic files which included their referral, appointment summaries, copies of prescriptions and complaints information. Only the administrators, registered manager, clinical leads and one non-medical prescriber had access to these records. This meant prior to clinic appointments, an administrator had to email the details of previous appointments to the clinician. This meant there was a risk from emailing information, and it was time consuming for the administrators. When clinicians completed their appointments, they sent their summaries to the administration team to add to the system, send to the GP and patient. This meant information was not added onto the systems timely. We reviewed 13 records and found five clinic entries missing from the records. This meant there was no record of the appointment, what was discussed, agreed and actions to take. The patient and GP would not have received the outcome either. There were handwritten notes dating back to 4 September 2021 awaiting scanning. This meant records were not current or complete.

Medicines management

The service did not use systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Staff did not follow systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were prescribed by appropriately qualified staff. Most consultations were carried out remotely and prescriptions were posted directly to patients for dispensing at their preferred pharmacy. However, there was no clear protocol for carrying out remote consultations describing how to verify patient identity, or to manage information confidentially when working from home.

Protocols for managing repeat prescriptions were not robust. Prescriptions checks were made at the clinic and a list of repeat prescriptions required was sent to the prescriber on the rota. However, the responsibilities of both staff completing the checks or the prescriber were not clearly defined. For example, the protocol asks, 'Have observations arrived if needed?' but does not describe the staff responsibility for ensuring these have been checked and are in range.

Information was not shared with patients GP's in a timely way. Staff told us that there was over a month's backlog of letters to be sent to GP's. For example, one of the records we looked at showed a GP letter was not sent until two months after their appointment. The provider had recruited additional administration staff to help improve this.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Records confirmed staff spoke with patients regarding their medicines including side effects.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Prescriptions were copied to patients records for future reference and prescription stationery was stored securely.

Staff did not follow current national practice to check patients had the correct medicines. The service did not complete regular medicines audits to ensure prescribing was in line with best practice guidelines.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. Managers did not fully investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not know what incidents to report and how to report them. Medicines incidents were not clearly logged so that themes and trends could be identified, and prompt action could be taken to bring about improvement. For example, there was no log of prescriptions not received by patients, or of prescription writing errors. Protocols did not describe how lost or incorrectly written prescriptions were managed.

At the last inspection in July 2021, staff were aware of the location of the incident reporting form which was accessible on the shared drive. However, at this inspection, incident forms were not in use. The incident log provided by the registered manager had four incidents dating back to April 2021. We cross referenced this log to a complaint summary which showed four prescribing incidents for one patient that had not been recorded as an incident. The registered manager said staff do not use the incident forms and do not routinely log incidents in patient records. This meant there was no comprehensive incident review process in place.

Managers did not investigate incidents thoroughly. Patients and their families were not involved in these investigations. The registered manager told us, and records confirmed that the extent of the incident investigations was a discussion with the multidisciplinary team regarding the complaint or the incident. Records did not demonstrate that the investigation included the review of records or other documentation.

Staff met to discuss the prescribing difficulties and had prescriber meetings which identified the feedback and looked at improvements to patient care. Changes implemented included reducing the numbers of prescriptions that prescribers were writing and splitting the coordination of prescriptions between two administrators.

Community mental health services for people with a learning disability or autism

Inadequate

Staff did not receive feedback from investigation of incidents. We reviewed the multidisciplinary meeting minutes for six months from May to October 2021, we found incidents and complaints were only discussed in one meeting. There had been a compliant investigation in July 2021, and this was not discussed at the multidisciplinary meeting to share learning.

Are Community mental health services for people with a learning disability or autism well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders did not have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed and were not visible in the service. However, they were approachable for staff.

The registered manager was based in South Wales and managed the service remotely by use of email, phone and virtual meetings.

The service had expanded as a result of acquiring new contracts. The registered manager identified that they needed additional resource and support to meet the demands of this additional work and they had created an action plan for recruitment. They had recruited a service manager who started in June 2021 as office manager and became the service manager in September 2021. They also recruited two office managers who started as administrators in August 2021 and became office managers in October 2021, who were settling into their roles. These staff had identified areas for improvement within the running of the service including oversight of the repeat prescriptions and record keeping.

Commissioners were concerned about the oversight of the service and ability to meet reporting requirements and had put an action plan in place which the contract manager was reviewing monthly.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

At the last inspection on 16 July 2019, staff were not receiving one to one supervision. The Supervision Policy dated 30 November 2018 stated there should be one to one meetings annually with the director and individual staff. Four staff files of the six reviewed did not include any evidence of supervision. The supervision schedule did not include all staff. This meant that the requirement notice had not been met and the registered manager had not developed a process to ensure all staff received supervision.

Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed six staff files and none of the files had appraisals, references or heath screening in. There was no record that the registered manager had checked their conduct in previous employment or their reasons for leaving. This meant the service were not assured that staff had the skills, and requirements to provide diagnostic interventions, care and treatment to patients.

Several documents including the “Information for Patients Regarding Obtaining Prescriptions” and “Prescriber Procedures” were undated; this made it difficult to locate and to show when they were created and updated.

The service did not have robust systems and processes in place for managing prescriptions. Clinical audits were not completed to support continuous improvement. Medicines related policies did not provide clear guidance for staff and clear lines of accountably were not identified.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care.

Policies and procedures did not provide staff with guidance of how to respond to a variety of situations. The LANCuk Remote Clinic Policy dated 25 March 2020 stated that the practitioner should ensure, "They confirm the identity of the client/service-user, at the outset of the appt" however, it does not say how. The "Information for Patients Regarding Obtaining Prescriptions" did not include what to do if the prescription was not received or could not be dispensed.

For administrative staff checking the prescriptions there was no guide to check for any errors, for example, where the prescription did not meet Controlled Drug prescription writing standards. Errors had occurred with a delay in prescriptions for patients. There was no clinic audit to check that repeat prescription checks were completed correctly. There was no action log to record where there was missing information. There was no system in place to record if a prescription was incorrectly written and not dispensed against or if a prescription was not received.

Due to the remote appointments, observations were not being completed face to face with patients. There was no guidance for patients or staff regarding what was acceptable for patient provided observations. We saw examples where a patient e-mailed the observation information, with no pictures of monitors.

There was no oversight of incidents. A complaint report we reviewed listed seven prescribing incidents, when cross referencing to the incident reports, four incidents were not reported as incidents. The incident forms were not in use and incidents were not recorded in individual patient records. This meant the registered manager did not have oversight of incidents and learning was not shared to reduce the likelihood of reoccurrence.

There was a risk register in place, with 17 risks which had all been added in November 2018. The register said the risks had been reviewed in June 2021 however, there was nothing recorded in the columns “additional mitigating actions and quarterly update” and “due date for actions completion”. This meant there was no record to show if risks had been reviewed and any progress had been made to reduce the risks.

Information management

Staff did not collect and analyse data about outcomes and performance and did not engaged actively in local and national quality improvement activities.

Patient records were not accurate, complete and contemporaneous. We saw a pile of handwritten clinic notes dating back to 4 September 2021 awaiting scanning. This meant patient information and clinic letters were not always readily available to staff to assist their prescribing and interventions. Five out of the 13 records we reviewed had missing summaries of appointments. Two records we reviewed had copies of prescriptions missing. This meant there was no record of the medicines prescribed.

The majority of clinicians did not have access to the electronic record system or patient files. Only three clinical staff had access. There was a reliance on the administrative team to provide clinicians with the information regarding patients

prior to their appointments. Clinicians could not add summaries to the electronic record system. Emailed or paper summaries were sent to the administrative team to type and send to the patient and their GP and to save into the records. This meant there was a delay in patients and GP's receiving their summaries and the clinicians could not access all of the patient information prior to the appointments. The registered manager told us that not all clinicians had access to the systems to avoid information being deleted.

The registered manager had appointed two full time clinicians to be based at Heywood from November 2021 with the aim of providing consistency regarding prescribing arrangements and availability for face to face appointments. They told us these clinicians would be provided with access to the record systems.

This section is primarily information for the provider

Enforcement actions

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not assess and manage risk well. Risk was not considered and recorded at each appointment. The service did not have robust systems and processes in place for managing prescriptions. There was not an incident reporting and investigation process in place that staff followed.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an accurate, complete and contemporaneous record in respect of each patient including contact made by the patient and summaries of appointments. Clinicians did not have access to the information they required and were unable to add information to the clinical recording system in a timely manner. Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not have robust systems and processes in place for managing incidents. Staff were not receiving supervision in line with the supervision policy.