Review of compliance

Priory Healthcare Limited

The Priory Hospital North London

Region:	London
Location address:	Grovelands House, The Bourne, Southgate, London N14 6RA
Type of service:	Hospital for people with mental health needs and/or problems with substance misuse
Date the review was completed:	November 2010
Overview of the service:	The hospital provides care and treatment to adults and adolescents with mental health problems. They also provide a service to people with substance misuse issues. People who use services are either privately funded or funded by the NHS. The hospital is situated in extensive grounds in north London and is within walking distance of public transport and local amenities.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that The Priory Hospital North London was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Meeting nutritional needs
- Cooperating with other providers
- Management of medicines
- Safety and suitability of premises
- Requirements relating to workers
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 21 October 2010, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

What people told us

We visited two wards in the hospital, the adult Ward and the adolescent Ward. Young people on the adolescent Ward told us they took part in a range of therapies and activities. One said they had found the therapy ‘very helpful’ and commented that ‘staff don’t push too much and also don’t let me sit back either’. They said that therapy had helped them to express their feelings more and they liked the support they got from other young people. One said ‘it feels like being part of a family’. They told us that a community meeting was held every morning for staff and young people and that at the meeting the ‘young people can have their say’ and their views are ‘taken on board by staff’.

Negative comments we received from the young people included ‘we don’t get talked to enough’ by staff and some staff interact with the young people whilst others do not. One young person said that they sometimes found it hard to approach staff directly and would like staff to take the initiative more in approaching them. One young person said that staff ‘say they can’t take you out because they are too short staffed’; and another told us ‘when things get out of control there are never enough staff’

The patients we spoke to on the adult Ward told us that ‘staff are responsive’ and ‘it is like a hotel here.’ They also said they had regular sessions with a psychologist and that staff ‘are knowledgeable and capable’ and ‘there are loads of activities’ including meditation and board games. Patients said staff were respectful and sensitive in their approach towards them and took notice of patient preferences. Patients on both wards described having a choice of food at meal times including a salad bar and said the food was generally, ‘good’ and ‘properly prepared’

What we found about the standards we reviewed and how well The Priory Hospital North London was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Patients generally felt involved in their care and were treated with sensitivity and respect. They told us they were able to express their views to staff, were listened to and see changes as a result. Most patients had individualised plans of care in place. However, one young person, who had been on the ward for three weeks, did not know who their primary nurse was and said they had not seen their care plan. The hospital’s own audit of nine care plans on the adolescent Ward showed that in only four instances had the young person been fully involved in the completion of the care plan and three care plans showed no involvement at all. There is a risk that by not involving patients in decisions about their care and treatment their individual needs will not be met.

Overall, we found that improvements are needed for this essential standard.

Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Arrangements were in place for obtaining consent to treatment for patients and signed consent forms were found in patient medical notes. However, for one patient

detained under Section 3 of the Mental Health Act 1983 a copy of the consent form required under Section 58 of the Act was found in the patient's medical notes but a copy was not attached to their medication chart. Failure to attach the consent form to the medication chart contravenes the Mental Health Act 1983 Code of Practice. Chapter 24.71 of the Code of Practice states that a copy of the signed consent form should be kept with the patient's medication chart in order to minimise the risk of the patient being given medication for which they have not given consent.

Overall, we found that improvements are needed for this essential standard.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

Patients were positive about the therapy they received at the hospital and described a wide range of therapeutic groups and activities as well as individual therapy taking place. On the adolescent Ward the young people were provided with educational activities and support to maintain contact with their schools and continue their school work. A new programme of groups and activities had been introduced in the week of our visit and this had been well received and seen as a big improvement. Patients generally receive care and treatment that meets their needs.

Overall, we found that The Priory Hospital North London was meeting this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

Patients were happy with the food provided by the hospital and had a choice of meals including a salad bar. Snacks were provided outside meal times and these were generally acceptable.

Overall, we found that The Priory Hospital North London was meeting this essential standard.

Outcome 6: People should get safe and coordinated care when they move between different services

One community consultant reported not receiving the majority of patient discharge summaries in the past but said that this had improved very recently. Generally, patient care planning involved community mental health teams and information was shared with other services and mental health professionals. It is important that this improvement is maintained and discharge summaries are sent to services receiving patients at the time of discharge or transfer so that patients continue to receive the care and treatment that they need.

Overall, we found that The Priory Hospital North London was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

We found out of date controlled drugs in the medication cabinet. In the treatment room we found medication that was no longer being used kept in a cardboard container rather than being stored in a locked box until removed by the pharmacist. Medication audits carried out by the pharmacist had been only partially completed. Poor monitoring and unsafe storage and disposal of medication increase the risk of patients being given out of date medication and/or the wrong medication.

Overall, we found that improvements are needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

There was a hole in the wall on the adolescent ward which was unsightly and if left as it is may become unsafe. However, generally the physical environment was pleasant and the premises safe and fit for purpose. A programme of refurbishment was taking place.

Overall, we found that The Priory Hospital North London was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

Checks were made on staff before they started work at the hospital including Criminal Records Bureau (CRB) checks and obtaining references. The management also regularly checked the professional registration status of staff thus ensuring that care and treatment was provided by suitably qualified staff.

Overall, we found that The Priory Hospital North London was meeting this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

Although staff to patient ratios appeared to conform to the provider's corporate standards all staff we spoke to said there had been many occasions when there had not been enough staff on duty and this had been detrimental to patient care. Insufficient numbers of staff may have contributed to the high number of incidents on the adolescent ward and patients' perceptions of not being talked to enough. Staffing levels had increased in the two weeks prior to our visit but there was no evidence that a needs analysis and risk assessment had been carried out as a basis for

deciding what level of staffing was sufficient to meet the needs of patients and maintain their safety.

Overall, we found that improvements are needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Although improvements had taken place since the employment of several new senior managers at the beginning of September 2010, 85% of nurses and healthcare assistants had not received an appraisal in the last twelve months. The majority of ward staff did not receive individual clinical supervision and it was not always possible for them to attend the group supervision provided due to staffing levels. Staff did not feel supported by managers following serious incidents. There were high rates of sickness and low morale amongst staff. People who use the service are generally safe but there are risks to their health and well being and quality of care given from poorly supported staff, frequent changes in the staff rota due to staff sickness, and failure to appraise the performance of staff and assist them to develop their skills.

Overall, we found that improvements are needed for this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

A number of audits had been carried out to assess and monitor the care and treatment provided to patients and their safety and there was some recent evidence of learning from incidents. There was evidence that actions were taken to address risks but these were not always followed up to ensure that improvements had been made. The system for gathering feedback from users of services was ineffective and very little information on the experiences of patients was gathered. Without effective monitoring of the quality of care, including patients' perspectives, there is a risk that they will receive inadequate and unsafe care and treatment.

Overall, we found that improvements are needed for this essential standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Generally patients' clinical records were completed appropriately and contained all the necessary information. However, an audit of 10 patient records on the adolescent ward carried out by the hospital showed that all 10 records were 'partially compliant ' for legibility and only four records were compliant in terms of any alterations made in the record being signed appropriately. If care records cannot be read and understood easily by all members of the care team there is a risk to the continuity and quality of care and treatment provided and the safety of patients.

Overall, we found that improvements are needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are minor concerns with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke to three young people on the adolescent ward and they told us that a community meeting was held every morning for staff and young people. At this meeting the 'young people can have their say' and their views are 'taken on board by staff'. One member of staff later gave us an example of how the young people had complained about the ward décor and that had led to a programme of redecoration. The young people described how they had tried to negotiate a later bedtime with staff at the community meeting. They also told us that a suggestions box was available where the young people could make anonymous suggestions and that staff were receptive to these. There was also an 'emotions' box where one young person told us they could post a description of what they were feeling and why. This box was opened once a week and the emotions discussed in a group meeting. The young people were given a choice of outings on a Wednesday evening.
One young person said they had been in hospital for a number of weeks but did not know who their primary nurse was and had not seen their care plan. The young person also said that 'staff could update you more on what's happening' with care.

Another young person, who had been in the hospital for four weeks, said they had been fully informed about their care and progress and expected to be in hospital for a further four weeks. This young person described going to a care planning meeting which was attended by their key worker and consultant and they had talked about progress being made and medication.
The two patients we spoke to on the adult ward both told us that staff were respectful and sensitive in their approach towards them and said that they had weekly meetings with professionals involved in their care. One patient said that staff had taken note of his preferences regarding the treatment of a medical condition.

Other evidence
The nurse in charge of the adult ward informed us that regular reviews of patient care took place each week and a range of professionals were involved in each patient's care and treatment. A staff member said that everyone on the adult ward had a care plan and risk assessments were reviewed everyday. She said that patients were involved in developing their care plan and given a copy. Three care records were examined in the adult ward. These contained detailed assessments, individual care plans and reviews.
We observed posters on both the adult and adolescent wards advertising the Independent Mental Health Advocacy Service provided by a local Mind organisation.
The daily programme of activities and groups was clearly displayed on the wall in the adolescent ward. A senior manager told us that the young people had become more involved in their care since a new programme of activities and groups had been started in same week as our visit.
We were shown new adolescent ward rules. These encourage the young people to respect the personal space of others and state that they should not go into other people's bedrooms. The rules also state that no form of bullying will be tolerated and this includes 'whispering, ignoring and teasing'. They also stress the importance of respecting other patients regardless of an individual's race, religion, culture, class or sexual orientation.
We reviewed a number of care records on both the adult ward and adolescent ward and these showed that consent to treatment had been sought and on most occasions obtained from patients. Where patients were detained under the Mental Health Act 1983 attempts had been made to explain the patients' rights under the Act, sometimes on repeated occasions, and these were documented in the case records.
The hospital subsequently provided us with a completed report of an audit of nine individual care plans on the adolescent ward dated 01/11/10. This audit showed that: four care plans had been completed with the involvement of the young person, three showed no involvement at all and two were rated 'partial compliance'; five of the nine care plans had been signed by the young person; and only two care plans recorded that they had been given to the young person. Seven of the care plans were stated to be an individualised plan of care for the patient and the other two were partially compliant. An action plan was attached to the audit stating that care plans would be discussed in staff supervision, there would be weekly monitoring of care plans and work with bank and agency nurses to ensure they are familiar with hospital policies.

Our judgement
Patients generally felt involved in their care and were treated with sensitivity and respect. They told us they were able to express their views to staff, were listened to

and see changes as a result. Most patients had individualised plans of care in place. However, one young person, who had been on the ward for three weeks, did not know who their primary nurse was and said they had not seen their care plan. The hospital's own audit of nine care plans on the adolescent ward showed that in only four instances had the young person been fully involved in the completion of the care plan and three care plans showed no involvement at all. There is a risk that by not involving patients in decisions about their care and treatment their individual needs will not be met.

Outcome 2:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:

- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are minor concerns with outcome 2: Consent to care and treatment

Our findings

What people who use the service experienced and told us
No specific comments were received.

Other evidence
A nurse on the adolescent ward explained that consent to treatment forms are kept in each young person's file and these are signed by the parent or carer, the doctor and the young person. She said that there was always an attempt to gain the consent of the young person even if the parent or carer had already given consent.
A nurse on the adult ward explained to us the process for gaining consent from a patient detained under the Mental Health Act 1983. She gave an example of a patient transferred to the ward on a Section 2 and described how repeated attempts had been made to explain his rights under the Mental Health Act 1983 to him. The nurse demonstrated knowledge of the Mental Health Act 1983 and the process of explaining rights under the Act, the right to appeal and the need to obtain consent.
We reviewed three medication charts on the adult ward and found that the charts were signed appropriately by doctors and nurses for medication prescribed and given and if medication had been refused this was clearly marked. The medication chart of one patient detained under Section 3 of the Mental Health Act 1983 did not have the consent/capacity to consent form attached. The consent form was later

located in the patent's file after several attempts. This showed that consent had been obtained from the patient as required under Section 58 of the Mental Health Act 1983.
The Mental Health Act Administrator told us that a central register is held containing all the details of all detained patients admitted. The file was reviewed and copies of completed consent forms seen. One patient's records in the central folder contained evidence that the patient had been read their rights and had signed to that effect, this had happened on two occasions. The consent and capacity to consent forms were in place and completed appropriately. There was a copy of a patient information sheet which we were told had been given to the patient, medical recommendations, and Approved Mental Health Practitioner reports. The Administrator also kept a detained patient chart which listed all the patients detained in the adult ward, the lead nurse and the date of the next review of detention. We saw that this was also displayed in the Ward office. The Administrator told us that she is ensuring that the hospital is compliant with the Mental Health Act and that appropriate procedures are followed.
We looked at a case file of a young person on the adolescent unit detained in hospital under Section 2 of the Mental Health Act. This included appropriate documentation including the patient's signature showing that she had had her rights explained to her. The consent to treatment form was signed by the patient's brother but not by the young person. Three medical records of non-detained patients were reviewed in the adult ward and these showed that patients had signed and agreed to their treatment.

Our judgement
Arrangements were in place for obtaining consent to treatment for patients and signed consent forms were found in patient medical notes. However, for one patient detained under Section 3 of the Mental Health Act 1983 a copy of the consent form required under Section 58 of the Act was found in the patients medical notes but a copy was not attached to their medication chart. Failure to attach the consent form to the medication chart contravenes the Mental Health Act 1983 Code of Practice. Chapter 24.71 of the Code of Practice states that a copy of the signed consent form should be kept with the patient's medication chart in order to minimise the risk of the patient being given medication for which they have not given consent.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We visited two wards in the hospital, the adult ward and the adolescent ward. On the adolescent ward we spoke to three young people who had been admitted. They all described a range of therapies and activities that they took part in on a regular basis. One said they had found the therapy 'very helpful' and commented that 'staff don't push too much and also don't let me sit back either'. They said that therapy had helped them to express their feelings more and they liked the support they got from other young people. One said 'it feels like being part of a family'. All three young people said they particularly enjoyed ward outings and described an outing the previous evening when a group of patients had gone bowling followed by a visit to a fast food restaurant. They had been given the choice of going to the cinema or going bowling. They also explained that they go for a walk everyday in the grounds of the hospital and visit an adolescent equipped gym twice during the week and recently those young people who remain in hospital at the weekend have also started going to the gym on Saturday. There was a television and DVD player in the lounge and we saw a number of board games and puzzles available for recreation. All of the young people had an allocated therapist and received individual therapy either twice or three times a week. The young people told us that there is a community meeting every morning and all the young people and staff attend. This is an opportunity for the young people to set individual goals for the day and as one said 'discuss things with the staff and other patients'. Each young person is given a

goals sheet to complete and every evening there is a review meeting with staff to discuss how the day went. Education is provided every week day until 5pm. One young person we spoke to said they sometimes went to education but 'I actually see my therapy as work and the main reason I am in hospital'. The two other young people said they went to the education room in the morning and afternoon and that the ward teacher could 'sort things out with school' so that work could be sent to them via email. We saw the education room which had about ten computers and four young people were working at a computer when we went in. The teacher explained that he liaised with each young person's school for individual work which he then tried to support them with. He said it was easier to give support to core subjects such as Maths and English.

The more negative comments we received from the young people included 'we don't get talked to enough' by staff and some staff interact with the young people whilst others do not. One young person said that they sometimes found it hard to approach staff directly and would like staff to take the initiative more in approaching them. Another said they had been in hospital for a number of weeks but did not know who their primary nurse was and had not seen a care plan. Two of the young people thought that staff could be more alert to what was going on in the ward and commented that some staff did not respond when young people appeared distressed.

We spoke to two patients on the adult ward and one told us that 'staff are responsive' and 'it is like a hotel here.' They also said they had regular sessions with a psychologist. Another patient said that staff 'are knowledgeable and capable' and also that 'there are loads of activities' including meditation and playing board games such as scrabble.

Other evidence

A senior manager at the hospital explained to us that a new programme of daily activities on the adolescent ward had been created and that this had started on Monday 18 October. All the young people we spoke to said they thought the new programme of activities was a big improvement. The programme was displayed on the wall in the ward. This showed a range of groups taking place throughout the week, including Saturday and Sunday. Examples of activities scheduled to take place included drama therapy, healthy emotions and "Beating the Blues" group. On the day of our visit we observed staff encouraging the young people to attend an anger management group which took place in a closed room on the ward.

A therapist working on the adolescent ward described several therapeutic groups which she ran including health promotion groups, lunch clubs and activities for those considered too unwell to join ward outings.

We were shown a draft copy of the Adolescent Unit Rules which outlined the behaviour expected of young people on the ward. We were told by the Medical Director that these were new. The rules state that visiting hours are from 4.30 – 8.30pm Monday to Friday and 10.45am – 8.30pm at weekends. One young person told us that their mother was due to visit that evening and take them out.

A staff member told us that on the addictions ward there is meditation every morning which is followed by group therapy. Most patients on the adult ward can go out if they are well enough and often families take them out. She also explained that those patients involved in the substance misuse programme cannot leave the hospital during treatment.

Our judgement

Patients were positive about the therapy they received at the hospital and described a wide range of therapeutic groups and activities as well as individual therapy taking place. On the adolescent ward the young people were provided with educational activities and support to maintain contact with their schools and continue their school work. A new programme of groups and activities had been introduced in the week of our visit and this had been well received and seen as a big improvement. Patients generally receive care and treatment that meets their needs.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The young people we spoke to on the adolescent ward described the food as ‘edible’, ‘good’ and ‘properly prepared’. They said there was generally a good choice and options including a salad bar. One young person thought the food was good but ‘a bit posh’ and there could be more burgers and chips on the menu. They thought it would be good to have ‘unhealthy’ options sometimes like crisps and chocolate. The young people said that bread was made available for toast to make snacks between meals otherwise they could also buy their own snacks. One said that they would like fruit to be made available as a snack in the evening as an alternative to bread or toast.
Patients who spoke to us on the adult ward said that they were happy with the meals provided and there was a choice at meal times.

Other evidence
Patients from the adult ward and the adolescent ward use the same dining room for meals but at separate times. The dining room is located close to the adult ward on the ground floor. We observed young people being escorted from the adolescent ward on the first floor to the dining room via an outside door and a short walk around the side of the building. The Medical Director explained that this was so that the young people would not have to enter the dining room by going through the adult ward.

Our judgement

Patients were happy with the food provided by the hospital and had a choice of meals including a salad bar. Snacks were provided outside meal times and these were generally acceptable.

Outcome 6:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us
The young people we spoke to on the adolescent ward told us that they had attended their own care planning meetings and had taken part in discussions about their care and treatment, although one young person said that the purpose of the meeting had not been properly explained to them.

Other evidence
The Medical Director explained that currently all young people admitted on the adolescent ward are NHS patients. They mostly come from three London boroughs with which they have contracts or from other areas when adolescent mental health beds are temporarily unavailable. Staff told us that individual care planning meetings regularly took place on the adolescent ward and health professionals from the Child and Adolescent Mental Health Services (CAMHS) were routinely invited and attended. One therapist we spoke to said that communication with the community teams was good and that they knew many of the community psychiatric nurses and social workers as the same ones come to the care planning meetings on a regular basis.
One case file belonging to a young person who was admitted to the adolescent ward for two months in 2010 was reviewed. A discharge summary was present in the file along with a copy of a discharge letter to the CAMHS team. There was also evidence of fortnightly feedback sent to the care co-ordinator and an invitation to a Care Programme Approach (CPA) meeting addressed to the CAMHS team. A

second case file of a young person currently admitted to the adolescent ward contained a letter to the referring CAMHS from the hospital Medical Director regarding the young person. The file notes that a CPA meeting took place but the CAMHS representative was unable to attend, however the family of the young person did attend. There was also a copy of a letter to social services regarding the young person's family issues along with an invitation to a CPA meeting.
The staff communications book kept in the office on the adolescent ward showed a number of messages recorded from social workers and family members.
We saw an email showing that arrangements had been made for a young person to attend an appointment with her CAMHS psychiatrist the day after her discharge from the adolescent ward.
We later spoke on the telephone to a consultant psychiatrist from a local Child and Adolescent Mental Health Service who confirmed that invitations to care planning meetings were received by the CAMHS teams and minutes of the meetings were sent to them afterwards. The consultant also said that 'very recently' they had started receiving discharge summaries for the young people transferred back to their care but in the past they had not received discharge summaries in the 'majority of cases'.
The hospital provided us with a completed audit of nine individual care plans on the adolescent ward dated 01/11/10 which showed that discharge care plans had not been completed. A senior manager told us that current practice is to start compiling the discharge care plan when the young person's clinical presentation improved, diagnosis made and future plan of care developed. Therefore it would not be unusual to see an audit where discharge plans had not been started. He explained that admissions to the adolescent ward were often crisis admissions and that it can take some time to draw up a long term plan of care.

Our judgement
One community consultant reported not receiving the majority of patient discharge summaries in the past but said that this had improved very recently. Generally, patient care planning involved community mental health teams and information was shared with other services and mental health professionals. It is important that this improvement is maintained and discharge summaries are sent to services receiving patients at the time of discharge or transfer so that patients continue to receive the care and treatment that they need.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us
No specific comments were received.

Other evidence
When we went to the hospital we visited the treatment rooms on both the adult ward and adolescent ward. The arrangements for storing medications for use on the wards were viewed. In the adolescent ward all medications were either stored safely in a locked cupboard or fridge. All those inspected were found to be in date.
In the medication cabinet on the adult ward we checked three medications in general use and these were in date. The Controlled Drugs Book was viewed and this had been completed appropriately. Evidence was seen of the amount received by the establishment, the stock balance and two signatures. On inspecting the controlled drugs cupboard we found two 50 ml bottles of methadone which had expired at the end of September 2010 and was therefore out of date.
The auditing records for out of date stock were inspected and was found to be complete for each month in 2009, but in 2010 only a small number of entries had been made in July and one each in October and November (noting the medication due to go out of date). In addition we found a cardboard box on the counter in the treatment room which contained a large amount of discarded medication. The medication had been prescribed to patients who had been discharged and was therefore no longer required. We were told that the medication was awaiting

removal by the pharmacist. When we pointed out that the auditing of out of date medication did not appear to have been carried out consistently in 2010, the nurse stated that it was the external pharmacist's role to do this. She did not have any knowledge of the process and was not aware of any oversight by ward staff of the pharmacist's audit.
We checked three medication charts on the adult ward and these had been completed. The signatures of the doctor prescribing the medication and the nurses giving the medication were clearly documented. The medication chart of one patient detained in hospital under Section 3 of the Mental Health Act 1983 was reviewed. The prescription chart did not have the completed consent/capacity to consent form attached. We later located the consent form in the patient's file and this showed that consent had been obtained from the patient.

Our judgement

We found out of date controlled drugs in the medication cabinet. In the treatment room we found medication that was no longer being used kept in a cardboard container rather than being stored in a locked box until removed by the pharmacist. Medication audits carried out by the pharmacist had been only partially completed. Poor monitoring and unsafe storage and disposal of medication increase the risk of patients being given out of date medication and/or the wrong medication.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is compliant with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
The hospital is set in extensive grounds and the young people on the adolescent unit told us that they go for a walk in the grounds everyday which they enjoyed.

Other evidence
A refurbishment programme began in the hospital in August 2010. The minutes from the Clinical Governance Committee meeting of 27/08/10 stated that five patient rooms on the adult wards had undergone improvements. Minutes of the hospital Clinical Governance Committee meeting on 24/09/10 stated four rooms on the adolescent ward have been refurbished, that the corridor is to be painted and decorated and new doors provided. All patients on both wards had single rooms. The adult ward was clean, light and airy and there was decorating taking place on the day of our visit.
There was a hole in the wall on the adolescent ward close to the staff office. We were told that this had been made by one young person and that despite repeated attempts to repair the hole the young person concerned had continued to kick a hole in the wall in the same place each time it was repaired.

Our judgement
There was a hole in the wall on the adolescent ward which was unsightly and if left as it is may become unsafe. However, generally the physical environment was pleasant and the premises safe and fit for purpose. A programme of refurbishment was taking place.

Outcome 12:
Requirements relating to workers

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
No comments on this outcome were received.

Other evidence
Several staff we spoke to told us that a Criminal Records Bureau (CRB) check was carried out and that they had supplied the details of two referees prior to starting work in the hospital. One qualified nurse told us that her current registration with the Nursing and Midwifery Council was also checked before she could commence work. Four staff personnel records were examined and these contained employment contracts, evidence of completion of an induction programme, two references and evidence of an identity check having taken place. There was, however, no evidence of a CRB check having been carried out. We were told by a senior manager that all CRB checks are done on staff prior to their starting work and some staff had recently had CRB checks repeated as they had been out of date. She said that CRB check documents were all kept in a central file in the Human Resources Department. We were unable to see this file on the day of our visit.
Following our visit to the hospital we were sent evidence that CRB checks had been carried out on all staff. This included the dates on which the CRB disclosure was obtained, the expiry date and reference number. The provider also gave us a spreadsheet showing the current professional registration details of all qualified nursing staff including the date of expiry and personal identification number.

Our judgement

Checks were made on staff before they started work at the hospital including Criminal Records Bureau (CRB) checks and obtaining references. The management also regularly checked the professional registration status of staff thus ensuring that care and treatment was provided by suitably qualified staff.

Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One young person on the adolescent unit said that staff 'say they can't take you out because they are too short staffed.' Another told us 'when things get out of control there are never enough staff' and went on to describe an incident that occurred recently when a group of young people were involved in a violent incident and the police had been called to the ward. They said that those young people not involved had been kept in the education room with a member of staff. Two members of staff told us about the same incident involving six or seven young people and which resulted in a hole in the wall, a broken window and inappropriate use of the fire extinguishers.
Young people also told us 'we don't get talked to enough' by staff and some staff interact with the young people whilst others do not.

Other evidence
Several members of staff on the adolescent ward told us that staffing levels had been very low until the last two weeks. One staff member described the adolescent ward as a 'very stressful environment to work in' and that because there were not always enough staff members on duty, the ward had felt very unsafe at times. She went on to describe a situation three weeks prior to our visit when there had been only two nurses on duty on the ward, which she felt had put the safety of young people and staff at risk. Recently there had been six or seven staff on duty during the day which she said was much better than before when it was often only three or

four staff on the day shift. Several staff told us that the senior management did not always bring in extra staff when a young person required one-to-one supervision although this had improved lately. One explained that there should be five staff on duty at night, two of whom are qualified nurses and this has been the case for the last two weeks. Prior to this sometimes there was only on qualified nurse on duty on the adolescent ward at night.
Another staff member we spoke to stated that staffing 'has been better for the last couple of weeks' but that six weeks ago there were 'definitely not enough staff'. She said that actual patient numbers might satisfy hospital staff to patient ratios but if one or two young people are on one-to-one observation throughout the shift then this leaves few staff free to care for the other young people.
Four staff interviewed on the adult ward stated that they thought the staffing levels were insufficient. As a result staff meetings were sometimes not held, patients had been put at risk and on occasions staff had not been able to prevent patients from absconding.
A senior manager at the hospital told us that they follow corporate staff to patient ratios and that on the adolescent unit the staff to patient ratio is 1:3 during the day and 1:4 at night and that if any young person requires one-to-one supervision then the numbers of staff needed are reviewed. On the adult ward the ratios are 1:5 during the day and 1:6 at night.
Six of the weekly nursing rotas for the adolescent ward in September and October 2010 and four rotas for the adult ward in September were viewed. These were compared with the hospital patient/ bed list for the month of September 2010. These showed compliance with the stated staff to patient ratios. However it was not possible to see retrospectively when patients had been on one-to-one observation and whether extra staff had been brought in as a result.
The rotas on the adolescent ward for the weeks commencing 4 October and 11 October showed high rates of sickness absence. In the week commencing 4 October seven members of staff recorded 10 days of sickness absence between them and in the following week this rose to 11 members of staff recording 21 days of sickness absence. There were 20 members of regular staff scheduled to work during that week. High rates of sickness amongst night staff on the adolescent ward meant that night shifts had to be covered by bank and agency nurses. In the week commencing 27/09/10 one qualified nurse worked six consecutive nights and in the week commencing 04/10/10 the rota shows that one team support worker worked six night shifts out of seven. This could lead to staff tiredness and may be detrimental to patient care.
A senior manager we spoke to confirmed that staff sickness on the wards was 'exceptionally high'.
Minutes of the hospital Clinical Governance Committee meeting on 24/09/10 noted that there had been ten recorded incidents on the adolescent ward since the previous meeting on 27/08/10. This was confirmed by one member of staff who said 'incident after incident is happening'.
There was no evidence that senior managers had carried out a needs analysis and/or risk assessment in relation to determining the staffing levels necessary to ensure that patients' needs were met and their safety maintained.

Our judgement
Although staff to patient ratios appeared to conform to the provider's corporate standards all staff we spoke to said there had been many occasions when there had not been enough staff on duty and this had been detrimental to patient care.

Insufficient numbers of staff may have contributed to the high number of incidents on the adolescent ward and patients' perceptions of not being talked to enough. Staffing levels had increased in the two weeks prior to our visit but there was no evidence that a needs analysis and risk assessment had been carried out as a basis for deciding what level of staffing was sufficient to meet the needs of patients and maintain their safety.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
No comments on this outcome were received.

Other evidence
We spoke to five members of staff on the adolescent ward. Four of them told us that they lacked support from senior management in the hospital. One person said 'it would be nice if someone would listen to me as we have more contact with patients'. Another said the senior managers were unapproachable and 'communication does not even exist', she added that managers were sometimes 'rude'. This was echoed by a third who said 'the management seem to find it difficult to understand what staff are asking for, they are not very flexible'.
One member of staff described a serious incident she had been involved in when a young person had harmed themselves. She said that no debrief or support had been offered to her following the incident and she had had nightmares about it since. This was similar to the experience of another staff member who told us about a serious incident in which the police were called to the ward. She said she did not receive any debrief or support from senior staff following the incident.
Only one of the staff we spoke to said she received individual clinical supervision, the other four, who were nursing or support workers, said they did not. They said that group supervision was provided every other Wednesday but because staff were so busy they could not always be relieved from their duties in order to attend. One occasion was described where the external supervisor sat in a room on her own as no one was able to attend the group. On another occasion staff took turns to relieve

each other and attended the supervision group one at a time.
A therapist we spoke to said she received regular clinical supervision from a therapist on another ward. She said she found this very helpful and it was a good time for reflecting on her work and getting some practical advice. She had also been put in touch with a network of therapists across the south of England and received peer support from a therapist at another Priory Hospital. She had completed a three month appraisal with her manager.
None of the other staff we spoke on the adolescent ward said they had received an appraisal in the last year although one person said she had twice set dates for this meeting with her manager but it had had to be cancelled on both occasions and no new date had been set.
We spoke to five members of staff on the adult ward and they told us that there was a good team spirit. They stated there had been recent improvements in the way they were managed and this had included a staff forum made available on the intranet.
A senior manager provided us with a list of 43 members of staff employed in the hospital (Nursing Staff – Appraisal List) as trained nurses, healthcare assistants, administration worker and teachers. This list showed dates of completed appraisals for seven of the 43 employees, six nurses and one administrator. These seven appraisals had all been completed since 26 September 2010 and had been carried out by one of the new senior managers who started work at the hospital in September 2010. None of the other 36 staff members had received an appraisal in 2010. Overall, only 15% of qualified nurses and healthcare assistants had received an appraisal in the last 12 months.
Minutes of the hospital Clinical Governance Committee meeting held on 24/09/10 stated an aim to complete 50% of staff appraisals by the end of October and 75% by the end of December 2010.
We looked at four staff training records. These records showed that the four staff had received training in basic life support, child protection, fire safety, health and safety, moving and handling, protection of vulnerable adults from abuse and the Mental Health Act, as well as other training, in the last 12 months.
Several staff members expressed the view that there had been improvements in the hospital since the arrival of a new management team in September 2010. One staff member said they hoped that ‘the arrival of the new medical director and clinical services manager is the start of something new’.
A senior manager told us that the annual colleague opinion survey had identified a lack of communication between staff and management. In response to this a monthly staff newsletter had been produced and there was a staff and management forum which takes place monthly. We were given copies of minutes of the staff management forum meetings that took place in May and July 2010 and a copy of the results of the colleague opinion survey conducted in 2009. The senior management team had produced an action plan in response to the results of the staff survey and progress notes stated that regular departmental team meetings were now held in all departments.
A senior manager we spoke to confirmed that staff sickness on the wards was ‘exceptionally high’. The rotas on the adolescent ward for the weeks commencing 4 October and 11 October showed high rates of sickness absence. In the week commencing 4 October 2010 seven members of staff recorded 10 days of sickness absence between and in the following week this rose to 11 members of staff recording 21 days of sickness absence. There had been 20 regular members of staff scheduled to work during that week. High rates of sickness amongst night staff on the adolescent ward meant that night shifts had to be covered by bank and

agency staff.

Our judgement
Although improvements had taken place since the employment of several new senior managers at the beginning of September 2010, 85% of nurses and healthcare assistants had not received an appraisal in the last twelve months. The majority of ward staff did not receive individual clinical supervision and it was not always possible for them to attend the group supervision provided due to staffing levels. Staff did not feel supported by managers following serious incidents. There were high rates of sickness and low morale amongst staff. People who use the service are generally safe but there are risks to their health and well being and quality of care given from poorly supported staff, frequent changes in the staff rota due to staff sickness, and failure to appraise the performance of staff and assist them to develop their skills.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:

- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
No comments on this outcome were received.

Other evidence
The hospital has systems in place for gathering information and evaluating the quality of care and treatment provided to patients. We were told by a Senior Manager that Clinical Governance meetings take place every month and that the findings of clinical audits are discussed. We looked at four sets of minutes from Clinical Governance Committee meetings held in February, August (two meetings held) and September 2010. All of these provided evidence of a range of audits being conducted including audits of therapy sessions, care planning, clinical documentation and suicide prevention. We also saw a report of an annual waste management and disposal audit that took place on 20/05/10 and an audit of patients detained under a section of the Mental Health Act between 19/05/10 and 18/06/10. There was evidence of risk assessment in the form of a regular environmental risk assessment and an audit of ligature points in the hospital carried out in October 2010. We saw a copy of a suicide prevention audit carried out on the adult ward on 23/10/10. The audit reviewed the contents of ten patient clinical files. Each patient had a risk assessment completed on admission. For three of the ten patients there was an identified suicide risk and for these three a risk assessment had been

completed and documented before any change in observation level made and the observation level was clearly identified. Of the seven patients not identified as a suicide risk, assessments of risk were being identified at regular intervals. An action plan was attached to the audit stating that the Ward Manager was responsible for weekly monitoring. We saw a hospital accident statistics record for 2010. This showed the number of accidents and incidents recorded and graded according to severity.

A senior manager told us that satisfaction surveys are sent out to patients after discharge by an external company and a quarterly report is shared at team meetings. We did not see evidence of a patient satisfaction survey report and the Clinical Governance Committee meetings noted on 27/08/10 that the survey was 'still ongoing but very poor' and stated that on discharge patients are given a card requesting them to provide their email addresses to be forwarded to the external company so that they could receive the questionnaire. Returns, however, had been poor and 'in a period of 3 months, 6 patients responded to this request'. The minutes for the meeting on 24/09/10 stated 'no feedback' in relation to the patient survey and that it was 'not successful and not working'. Staff on the adult ward told us that there had been no patient surveys in the last year. Therefore the provider is receiving very little in terms of feedback from people who use services. One staff member told us that the patients forum was to be restarted in October, 'the first this year'.

There was some evidence that learning had taken place and changes made in response to adverse events and incidents. Minutes of the hospital Clinical Governance Committee meeting on 24/09/10 noted that there had been ten recorded incidents on the adolescent ward since the previous meeting and linked these incidents to boredom in the evenings and a lack of structure in the day time activity programme for the young people. It was agreed at this meeting that a full review of the programme would be carried out to identify where additional therapeutic resources were needed. It was also stated that additional staffing would be provided on the ward between 5pm – 9pm to assist with activities. During our visit to the adolescent ward three young people told us about the new activities programme on the ward which they said was a big improvement.

Generally, however, there was little evidence that where risks had been identified and action plans put in place that these were followed up effectively to ensure that improvements were made.

Our judgement

A number of audits had been carried out to assess and monitor the care and treatment provided to patients and their safety and there was some recent evidence of learning from incidents. There was evidence that actions were taken to address risks but these were not always followed up to ensure that improvements had been made. The system for gathering feedback from users of services was ineffective and very little information on the experiences of patients was gathered. Without effective monitoring of the quality of care, including patients' perspectives, there is a risk that they will receive inadequate and unsafe care and treatment.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are minor concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us
No comments on this outcome were received.

Other evidence
Three patient care records were examined in the adult ward. These contained detailed assessments, care plans and reviews. The nurse in charge informed us that regular reviews took place each week and a range of professionals were involved in their care. They also contained risk assessments and evidence that those people assessed as being high risk were closely monitored. Records of close observations carried out had been completed. The care plans and consent forms had been signed by the patients.
The provider gave us a copy of a medical records audit carried out by the Mental Health Act Administrator in May 2010 this stated that all the medical records were stored securely, the keys to the records were held securely and could be accessed 'out of hours' by clinical staff. It also stated that records were sent for external storage after three years but could be retrieved in one day; there was an approved contractor in place for the disposal of records.
A copy of a clinical documentation audit tool completed for the adolescent ward and dated 01/11/10 was also provided. This audit of 10 patient records showed that all of them contained daily care and progress notes made by all health professionals

involved in the care of the young people, copies of incident and accident forms, completed observation sheets for all periods the young person was placed under observation and copies of section papers where the young person was detained under the Mental Health Act 1983. All the entries were dated and the individual levels of observation required noted. However all of the records were noted to be only partially compliant for legibility; only four of the records were stated to be fully compliant in terms of them being signed and accompanied by the name and designation of the signatory; four records were fully compliant in relation to the documentation of alterations or additions in the record being made, three were partially compliant and three were not compliant. All the records were said to be written in terms that could be easily understood by patients. There was an action plan attached to the audit which stated monitoring of clinical documentation would take place weekly.

Our judgement
Generally patients' clinical records were completed appropriately and contained all the necessary information. However, an audit of 10 patient records on the adolescent ward carried out by the hospital showed that all 10 records were 'partially compliant ' for legibility and only four records were compliant in terms of any alterations made in the record being signed appropriately. If care records cannot be read and understood easily by all members of the care team there is a risk to the continuity and quality of care and treatment provided and the safety of patients.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury; Accommodation for persons who require treatment for substance misuse; Diagnostic and screening procedures</td><td>15</td><td>Outcome 10: Safety and suitability of premises</td></tr>
<tr><td colspan="2">Why we have concerns:
Generally the physical environment was pleasant and the premises safe and fit for purpose. However, there was a hole in the wall on the adolescent ward which was unsightly and if left as it is may become unsafe.</td></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury; Accommodation for persons who require treatment for substance misuse; Diagnostic and screening procedures</td><td>24</td><td>Outcome 6: Cooperating with other providers</td></tr>
<tr><td colspan="2">Why we have concerns:
One community consultant reported not receiving the majority of patient discharge summaries in the past but said that this had improved very recently. Generally, patient care planning involved community mental health teams and information was shared with other services and mental health professionals. It is important that this improvement is maintained and discharge summaries are sent to services receiving patients at the time of discharge or transfer so that patients continue to receive the care and treatment that they need.</td></tr>
</table>

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury; Accommodation for persons who require treatment for substance misuse; Diagnostic and screening procedures	17	Outcome 1: Respecting and involving people who use services
	How the regulation is not being met: One young person, who had been on the ward for three weeks, did not know who their primary nurse was and said they had not seen their care plan. The hospital's own audit of nine care plans on the adolescent ward showed that in only four instances had the young people been fully involved in the completion of the care plan and three care plans showed no involvement at all. There is a risk that by not involving patients in decisions about their care and treatment their individual needs will not be met.	
Treatment of disease, disorder or injury; Accommodation for persons who require treatment for substance misuse; Diagnostic and screening procedures	18	Outcome 2: Consent to care and treatment
	How the regulation is not being met: For one patient detained under Section 3 of the Mental Health Act 1983 a copy of the consent form required under Section 58 of the Act was found in the patient's medical notes but a copy was not attached to their medication chart. Failure to attach the consent form to the medication chart contravenes the Mental Health Act 1983 Code of Practice. Chapter 24.71 of the Code of Practice states that a copy of the signed consent form should be kept with the patient's medication chart in order to minimise the risk of the patient being given medication for which they have not given consent.	
Treatment for disease, disorder or injury: Accommodation for persons who require treatment for substance misuse; Diagnostic and screening procedures	13	Outcome 9: Management of medicines
	How the regulation is not being met: We found out of date controlled drugs in the medication cabinet. In the treatment room we found medication that was no longer being used kept in a cardboard container rather than being stored in a	

	locked box until removed by the pharmacist. Medication audits carried out by the pharmacist had been only partially completed. Poor monitoring and unsafe storage and disposal of medication increase the risk of patients being given out of date medication and/or the wrong medication.	
Treatment of disease, disorder or injury; Accommodation for persons who require treatment for substance misuse; Diagnostics and screening procedures	22	Outcome 13: Staffing
	How the regulation is not being met: Although staff to patient ratios appeared to conform to the provider's corporate standards all staff we spoke to said there had been many occasions when there had not been enough staff on duty and this had been detrimental to patient care. Insufficient numbers of staff may have contributed to the high number of incidents on the adolescent ward and patients' perceptions of not being talked to enough. Staffing levels had increased in the two weeks prior to our visit but there was no evidence that a needs analysis and risk assessment had been carried out as a basis for deciding what level of staffing was sufficient to meet the needs of patients and maintain their safety.	
Treatment of disease, disorder or injury; Accommodation for persons who require treatment for substance misuse; Diagnostic and screening procedures	23	Outcome 14: Supporting workers
	How the regulation is not being met: Although improvements had taken place since the employment of several new senior managers at the beginning of September 2010, 85% of nurses and healthcare assistants had not received an appraisal in the last twelve months. The majority of ward staff did not receive individual clinical supervision and it was not always possible for them to attend the group supervision provided due to staffing levels. Staff did not feel supported by managers following serious incidents. There were high rates of sickness and low morale amongst staff. People who use the service are generally safe but there are risks to their health and well being and quality of care given from poorly supported staff, frequent changes in the staff rota due to staff sickness, and failure to appraise the performance of staff and assist them to develop their skills.	
Treatment of disease, disorder or injury; Accommodation for persons	12	Outcome 16: Assessing and monitoring the quality of service provision

who require treatment for substance misuse; Diagnostic and screening procedures	**How the regulation is not being met:** A number of audits had been carried out to assess and monitor the care and treatment provided to patients and their safety, and there was some recent evidence of learning from incidents. There was evidence that actions were taken to address risks but these were not always followed up to ensure that improvements had been made. The system for gathering feedback from users of services was ineffective and very little information on the experiences of patients was gathered. Without effective monitoring of the quality of care, including patients' perspectives, there is a risk that they will receive inadequate and unsafe care and treatment.	
Treatment of disease, disorder or injury: Accommodation for persons who require treatment for substance misuse; Diagnostic and screening procedures	20	Outcome 21: Records
	How the regulation is not being met: Generally patients' clinical records were completed appropriately and contained all the necessary information. However, an audit of 10 patient records on the Adolescent Ward carried out by the hospital showed that all 10 records were 'partially compliant ' for legibility and only four records were compliant in terms of any alterations made in the record being signed appropriately. If care records cannot be read and understood easily by all members of the care team there is a risk to the continuity and quality of care and treatment provided and the safety of patients.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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