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 services for people with mental health needs, learning disabilities and problems with substance misuse Residential substance misuse treatment and/or rehabilitation service
Date of Publication:	July 2012
Overview of the service:	The Priory Hospital North London provides care and treatment to adults and adolescents with mental health needs. They also provide a service to people with substance misuse problems. People who use services are either privately funded or funded by the

	NHS. The hospital is situated in extensive grounds in north London. There is a registered manager in place.

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

Our current overall judgement

The Priory Hospital North London was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 28 May 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

During our visit to The Priory Hospital North London we visited the adolescent unit. We spoke to four of the 18 young people who were patients on the unit at the time. The young people said they did not feel safe or protected particularly from some of the other young people. Staff were described as 'not in control' of the unit and they felt that concerns for their personal safety were not taken seriously by staff. The young people told us there were not enough activities provided for them, particularly at the weekends. Those that were scheduled often did not take place. One young person described the weekends as 'awful'.

Three of the young people we spoke with told us there were usually not enough staff on duty to meet their needs. This meant that they were often unable to go outside for a walk. Those not receiving one-to-one care had little time with staff and their needs were not always met.

We found that agency staff did not always receive an adequate induction when they came to the ward. An agency nurse induction checklist had been prepared by managers but was not yet in use. A typical comment we received from one young person was, 'agency staff don't know about young people'. This meant there was a risk that agency staff were not appropriately supported to enable them to deliver care to the young people safely.

Evidence of the legal detention of one young person in the hospital could not be located on the day of our visit. This could have resulted in a failure to uphold the person's rights under the Mental Health Act 1983.

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

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The delivery of care did not always meet the needs of the young people. Young people were not being adequately protected against the risks of receiving inappropriate or unsafe care.
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

Young people were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.
The provider was meeting this standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.
The provider was meeting this standard.

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

The provider was not taking appropriate steps to ensure that, at all times, there were enough qualified, skilled and experienced staff to safeguard the health, safety and welfare of the young people and meet their needs.
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider did not have suitable arrangements in place to support and supervise staff and not all staff had received appropriate training. As a result there was risk that care and treatment were not always provided to an appropriate standard.
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

Records were not always accurate and could not be located promptly. As a result young people were not always being protected against the risks of unsafe or inappropriate care.
The provider was not meeting this standard. We judged that this had a minor impact on

people using the service and action was needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 04:
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 non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to four of the 18 young people who were patients on the adolescent unit. They told us that communication between staff was quite poor. They said that important information about them was not always handed over from one shift to another. One patient described how staff had handed over incorrect information about them. Another said that staff caring for them often did not know what was in their care plan.

The young people told us there were not enough activities provided for them, particularly at the weekends. Those that were scheduled, such as 'movie night', did not usually take place. One young person described the weekends as 'awful'. For those aged over 16 years who had opted out of education there was nothing else for them to do during school hours. The young people were disappointed that access to a local gym had recently stopped due to the expiry of the contract. However, there was a group outing one evening a week and they described some group activities such as music imagery that they liked and found helpful.

One young person told us they met with their key worker every week and reviewed their care plan whilst another said they only saw their care plan at ward rounds. This showed that patient involvement in care planning was inconsistent.

We were given a copy of the results of the patient satisfaction survey for the adolescent unit for the period January to March 2012. The report showed low levels of patient satisfaction with the service. For example, the overall level of satisfaction with the

service was 58% and level of happiness with the service was 34%. This was a substantial drop of 24% in satisfaction and 18% in happiness levels compared to previous quarters and showed the service to have the lowest satisfaction and happiness levels of all nine of the provider's child and adolescent services. 50% of patients were unhappy with the services offered to them and 60% described themselves as either 'unhappy' or 'very unhappy' with the service they had received.

Other evidence
All three staff we spoke to told us that there was often little for the young people to do in the evenings and at weekends. One told us that scheduled groups 'don't always happen' and there was little opportunity for physical activities for the young people. As a result there was a risk that care was not being delivered in a way that met young people's needs.

We reviewed the care plans and risk assessments of five young people. These showed that their needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Risk assessments focussed on the safety of the individual, for example, in terms of self harm and risk of suicide. These had been regularly reviewed and updated where necessary. Staff said they did not always have time to update themselves on the care plan of the young person as they were usually carrying out one-to-one observations on young people throughout their shift. As a result there was a risk that staff were unaware of changes in patients' care plans and therefore not adequately prepared to meet their needs.

Our judgement
The delivery of care did not always meet the needs of the young people. Young people were not being adequately protected against the risks of receiving inappropriate or unsafe care.
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The young people we spoke with during our visit said that staff generally treated them well. They told us of several staff who had been particularly helpful to them during their admission. They did not tell us of any incidents of abuse.

Other evidence
The provider had responded appropriately to any allegations of abuse and we were aware that referrals to the local safeguarding authority had been made when appropriate.

Risk assessments were carried out on all the young people in relation to the risk of suicide. Environmental adjustments had been made to remove ligature points and other potential risks to safety. The provider had taken reasonable steps to identify the risk of suicide or self-harm and prevent it from happening.

We spoke with three members of staff. They knew how to identify abuse or the possibility of abuse and knew what action to take if they were concerned about the safety of the young people.

Our judgement
Young people were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The provider was meeting this standard.

Outcome 09:
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

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We spoke with several young people who told us they knew what medication was prescribed for them and what it was for. Possible side-effects had been explained to them.

Other evidence
We checked medication administration records for three young people. Staff had signed when medications had been given or recorded that a medication was not administered, although the reason was sometimes not recorded.

We saw that emergency drugs were kept in a sealed bag and were within the expiry date. We checked a sample of medications stored in the drugs cabinet and these were all within the expiry date.

We observed that the drugs fridge was locked and all medications were stored securely. The fridge temperatures had been checked regularly in order to ensure that medications were stored at the correct temperature.

We saw a copy of a pharmacy audit conducted by an external pharmacist. This identified a number of concerns in relation to medication administration. An action plan had been put in place to address the issues identified. As part of the action plan weekly reviews of medication administration were taking place in order to identify and address any shortfalls in the management of medicines.

Our judgement
People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.
The provider was meeting this standard.

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

The provider is non-compliant with Outcome 13: Staffing. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
Three of the young people we spoke with told us there were usually not enough staff on duty to meet their needs. The other young person did not comment on this.

Young people told us that because of staff shortages one staff member sometimes cared for two young people when both required one-to-one care. One young person gave us an example of when a staff member was caring for two young people on one-to-one care but was positioned in such a way that they could not see either of them. Young people were placed on one-to-one care when there were serious concerns for their safety or the safety of others. There was a risk that the prescribed level of observations were not being carried out and the safety of the young people concerned was not protected.

The young people said they were supposed to be able to go for a walk in the grounds once a day but there were usually not enough staff to take them. Planned activities were frequently cancelled due to a shortage of staff. Young people also told us that those young people not being cared for on a one-to-one basis had little time with nursing and support staff because staff were busy with the other young people. This meant there were not suitable numbers of staff to safeguard the health and safety of all the young people.

Young people said they did not feel safe or protected on the unit particularly from some of the other young people. Staff were described as 'not in control' of the unit. They were concerned that the unit rules were applied inconsistently by staff which was felt to be

unfair. One young person said staff sometimes ignored the fact that rules had been broken which left them feeling unsafe.

Other evidence
We spoke with three members of staff and they told us that a lot of 'bank' and 'agency' staff were used on the unit. Agency staff were described as lacking basic skills. The hospital provided us with information that showed that agency nurses and support workers were increasingly being used to cover a shortfall in permanent staffing numbers. For example, in March 2012 agency staff were used on the adolescent unit on 27 occasions. In April agency staff were used on 36 occasions and in May this had risen to 40 occasions. As a result, young people were sometimes being cared for by staff they did not know and who were not sufficiently familiar with the ward routine and expectations. There were no records to show that agency staff had undergone an induction before starting to work on the unit. As a result there was a risk that agency staff were not suitably experienced or skilled to safeguard the health, safety and welfare of the young people. Managers told us they were trying to recruit permanent staff but it was difficult to attract staff with the necessary skills and experience.

One staff member said the unit was 'understaffed'. Another agreed saying, 'staffing levels are not sufficient to meet the needs of the young people' and the third said that staffing levels were 'not great'. With many young people requiring one-to-one care from a staff member there were sometimes no staff available to care for the other young people. One staff said, 'the young people complain they don't get to speak to staff'. Another said that sometimes a young person would self-harm in order to attract the attention of staff. Staff confirmed that planned activities with the young people and walks in the hospital grounds were often cancelled due to a lack of staff to accompany the young people. This meant that there were insufficient numbers of staff to meet the care needs of all the young people.

Staff told us there had been a number of serious incidents on the ward recently and members of staff had been assaulted, which was confirmed by the provider's incident reporting system. The police had been called to the unit on one occasion. They said this was an indication that staffing levels were not safe.

Our judgement
The provider was not taking appropriate steps to ensure that, at all times, there were enough qualified, skilled and experienced staff to safeguard the health, safety and welfare of the young people and meet their needs.
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 14:
Supporting staff

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

The provider is non-compliant with Outcome 14: Supporting staff. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
The young people we spoke with considered that agency staff lacked knowledge of how to care effectively for young people with mental health needs. For example, one young person said, 'agency staff don't know about young people', and another said, 'agency (staff) are really bad they don't understand mental health'.

Other evidence
The hospital provided evidence of training completed by staff during the previous 12 months. The majority of staff had undertaken the required mandatory training. However, two of the three staff we spoke with told us they had not had recent training in safeguarding children or child protection. Staff training information, provided to us by the registered manager, showed that while 63% of healthcare assistants on the adolescent unit had completed training in safeguarding children and child protection, only 38% of trained nurses had completed the training. Consequently there was a risk that not all staff had received appropriate training to enable them to care for young people safely.

The provider had a supervision policy in place but this was not being followed consistently. Staff had access to fortnightly group supervision from an external facilitator. Staff told us they found this group helpful although were rarely able to attend due to shift patterns and staffing levels. Two of the three staff we spoke to told us they had not had any individual clinical supervision in over a year. A third received supervision monthly in line with the supervision policy and supervised more junior staff on a regular basis. However, there was a risk that the knowledge, skills and development needs of staff were not always identified, which may have meant they

were not able to deliver care safely and effectively to young people.

We spoke with three members of staff and they told us that a lot of 'bank' and 'agency' staff were used on the unit. Agency staff were described as lacking basic skills and 'unprepared for the work'. Some staff told us that agency staff received little or no induction when coming to the unit and were not always told about the needs of the young people they were caring for. Managers told us that an agency nurse induction checklist had been prepared but this was not yet in use. This meant there was a risk that agency staff were not appropriately supported to enable them to deliver care to patients safely as they did not receive adequate induction and preparation.

Our judgement
The provider did not have suitable arrangements in place to support and supervise staff and not all staff had received appropriate training. As a result there was risk that care and treatment were not always provided to an appropriate standard.
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider is non-compliant with Outcome 21: Records. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with young people using the service but their feedback did not relate to this standard.

Other evidence
We looked at the records of two young people who we were told were detained under the Mental Health Act 1983. The records of one young person did not contain a copy of the section papers. A nursing risk assessment did not mention that the young person was legally detained in hospital and their medication administration record recorded their status as 'informal'. We asked to see a copy of the section papers on the day of our visit but they could not be found. We were told by the manager that the papers had been 'locked away' by the Mental Health Act Administrator and the key was unavailable. Records to demonstrate the young person's lawful detention could not be located promptly. This meant that staff unfamiliar with the young person could have been unaware of the patient's legal status. This could have resulted in a failure to uphold their rights under the Mental Health Act. Without accurate records about a patient being available to all of those concerned in their care and treatment patients were not being adequately protected against the risks of unsafe or inappropriate care.

The manager confirmed to us two days later that the young person had been formally detained under a section of the Mental Health Act two days before our visit and a copy of the necessary papers had been retained in their medical records after our visit.

Our judgement
Records were not always accurate and could not be located promptly. As a result young people were not always being protected against the risks of unsafe or inappropriate care.
The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Action
we have asked the provider to take

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The delivery of care did not always meet the needs of the young people. Young people were not being adequately protected against the risks of receiving inappropriate or unsafe care.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The delivery of care did not always meet the needs of the young people. Young people were not being adequately protected against the risks of receiving inappropriate or unsafe care.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The provider was not taking appropriate steps to ensure that, at all times, there were enough qualified, skilled and experienced staff to safeguard the health, safety and welfare of the young people and meet their needs.	

Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The provider was not taking appropriate steps to ensure that, at all times, there were enough qualified, skilled and experienced staff to safeguard the health, safety and welfare of the young people and meet their needs.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The provider did not have suitable arrangements in place to support and supervise staff and not all staff had received appropriate training. As a result there was risk that the care and treatment were not always provided to an appropriate standard.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The provider did not have suitable arrangements in place to support and supervise staff and not all staff had received appropriate training. As a result there was risk that the care and treatment were not always provided to an appropriate standard.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Records were not always accurate and could not be located promptly. As a result young	

	people were not always being protected against the risks of unsafe or inappropriate care.

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 7 days of the date that the final review of compliance report is sent to them.

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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 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

Document purpose	Review of compliance report
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