Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Priory Hospital North London

Grovelands House, The Bourne, Southgate, London, N14 6RA

Tel: 02088828191

Date of Inspection: 18 April 2013

Date of Publication: May 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Priory Healthcare Limited
Registered Manager	Ms. Alexandra Blatch
Overview of the service	The Priory Hospital North London provides care and treatment to adults and children with mental health needs, including patients detained under the Mental Health Act 1983. A service is also provided to people with substance misuse problems. Patients are either privately funded or funded by the NHS.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 April 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and reviewed information we asked the provider to send to us.

What people told us and what we found

During this inspection we visited the adolescent unit and the addictions treatment programme. We spoke with several young people who were admitted to the adolescent unit. Most patients were satisfied with the care and treatment provided. One patient told us that their care was "good" and staff were "nice." Comments from patients who had completed patient satisfaction questionnaires on the adult ward and from those taking part in the addictions treatment programme included "I felt safe, secure and cared for" and "very caring and committed staff."

Patients were satisfied with the environment in which they received care, although the adolescent ward was described as generally quite hot and lacking ventilation. Appropriate arrangements were in place to ensure that medicines were managed safely. Complaints about the service were investigated and managed appropriately.

However, we found that not all care plans and risk assessments were reviewed in line with specified review dates in order to ensure that patients' individual needs were being met. Records kept in respect of patients' care and treatment were not always accurate and could not always be located promptly. Information provided to staff about patient care, legal status and capacity to give consent was sometimes contradictory or was not always immediately available to them.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 29 May 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patient's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Patients told us that their dignity and privacy had been respected by staff. We observed staff treating patients with consideration and respect in both wards we visited. However, one female patient, who was being cared for on a one-to-one basis by staff, told us that male staff were frequently assigned to closely observe her. She said she would have been more comfortable with female staff. We spoke with the ward manager who told us that the gender of patients was considered when allocating staff but it was not always possible to provide staff of the same gender to those being observed closely. The patient explained that when she had a bath she asked for a female staff member to accompany her. Female staff were always provided in these circumstances.

Some patients said that their care and treatment had been explained to them in a way they understood and they felt able to ask the questions they wished. However, the provider may wish to note that one patient who was detained under the Mental Health Act 1983 could not remember their rights under the Act being explained to them by staff. We found one record in the patient's notes stating that staff had tried to explain their rights to them but there was no record of any further attempts by staff or confirmation that the patient had appeared to understand. We raised this with the ward manager who said they would ensure the patient's rights were explained to them again.

Patients expressed their views and were involved in making decisions about their care and treatment. Care plans had been signed by patients to show they understood and we saw patient's views on their care recorded in their health care records. An independent advocate, provided by another organisation, visited the ward regularly and they could support patients to raise their concerns or raise issues on behalf of patients. We saw a poster advertising twice monthly visits to the hospital by an advocate.

Patient's diversity, values and human rights were respected. Staff we spoke with understood the cultural and religious needs of patients. They gave examples of adjustments made to the way care was provided to ensure patient's values were respected.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had not taken proper steps to ensure patients were protected against the risks of receiving inappropriate or unsafe care and treatment. Assessments of patient's needs were not always reviewed by specified dates and there was a risk that patient's individual needs were not being met and their welfare and safety was not ensured. Regulation 9(1)(a)(b)(i)(ii)

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with patients on the adolescent unit about their care and treatment. Most patients were satisfied with the care and treatment provided. One patient told us that their care was "good" and staff were "nice."

We observed an activity group taking place on the adolescent unit which involved the young people in painting a mural on the wall. A television and a variety of games were available in the lounge. A patient told us they had been able to attend their own school from the hospital. Others took part in educational activities in the unit's own school. One young person told us, however, "there are no activities at the weekend."

We reviewed the care plans and risk assessments of seven patients on the adolescent unit. These showed that patients' needs were assessed and individual risk assessments had been carried out. However, we found that not all care plans had been reviewed in line with specified review dates. Care plans of four patients out of the seven we checked had not been reviewed in line with the date set for review by staff. For one patient all four care plans in place were overdue their review by more than two weeks. One care plan in relation to the young person's suicidal ideas had not been reviewed for more than three weeks after the stated review date. There was a risk that the needs of the young person had changed in the intervening period of time and the planning and delivery of care may no longer have met their needs and ensured their safety and welfare.

Three other patients also had care plans where review dates had passed. For example, one young person had been provided with an initial care plan on their admission to the ward, five days before our inspection. The date given for reviewing the care plan was 15 April 2013. However, on 18 April the initial care plan had not been reviewed. The risk assessment for the young person stated they were considered to be a 'high risk' and the risk of suicide was highlighted. By failing to review the care plan by the date stated there

was a risk that the young person's needs were not being met and care and treatment was not being delivered in such a way as to maintain their safety. Although the provider had a system in place to ensure that care plans and risk assessments were reviewed by specific dates in order to ensure that patients' individual needs were met, this was not always effective. Staff had not reviewed and updated all care plans as specified for several patients. As a result patients were not always being protected against the risks of receiving inappropriate or unsafe care.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Patients we spoke with told us their medicines had been explained to them and they knew what they were for.

Appropriate arrangements were in place in relation to the recording of medicines administered to patients. We reviewed medication administration records for several patients on the adolescent unit. We found that these were completed appropriately and accurately. We saw the controlled drug registers and these were checked and completed on a daily basis or when a controlled drug was administered to a patient.

There was a fridge on the ward for medicines requiring cold storage at the right temperature. Records showed that fridge temperatures were checked on a daily basis to ensure they were within the required range. Medicines were stored safely in locked cupboards, trolley and drugs fridge. Access to the treatment room, where medicines were stored, was secure. This helped ensure that patients were protected against the risks of unsafe storage of medicines.

We checked a sample of medicines stored in the drugs cupboard and fridge on the adolescent unit and found that these were all within the expiry date and safe to use. Liquid medicine bottles had been clearly marked with the date of opening and expiry. A pharmacist visited the wards regularly and provided information and advice about medicines to staff.

A recent drug administration error had been fully investigated by the registered manager and action taken to reduce the risk of reoccurrence. No harm had been caused to the patient who had been taken to an accident and emergency department for medical checks as a precaution.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

Health and safety risk assessments had been undertaken and plans were in place to manage the risks identified. Staff carried out daily and weekly checks on the safety of the premises. This enabled them to identify and manage potential sources of risk to patients. An audit of ligature points had been conducted and unsuitable items, such as mirrors, had been removed from rooms or plans were in place to manage the risks that could not be removed. There were appropriate measures in place in relation to the security of the premises.

The provider had taken steps to separate the bedrooms for boys and girls on the adolescent unit. Each young person had their own ensuite bedroom and boys and girls rooms were on separate corridors.

Patients on the adolescent unit were mostly satisfied with the environment in which they received care, although the ward was described as generally quite hot and lacking ventilation. Two young people showed us their rooms and we saw these had been personalised with their own belongings.

However, the provider may wish to note that five chairs in the young people's lounge were ripped and some stuffing from inside the chairs had been removed. In addition, one young person showed us their bedroom, which was a designated high dependency room. We saw that the room did not have curtains and the young person was concerned that their privacy and dignity could not always be assured as people could potentially see in from outside. We discussed with the manager how this could be remedied without compromising the safety of patients using the room.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet patient's needs.

Reasons for our judgement

Patients were provided with the care and treatment they needed. There were seven staff on duty on the adolescent unit on the day we visited. Three of these staff were assigned to observe patients closely on a one-to-one basis. Four other staff provided care and treatment to the remaining young people. Staff rotas confirmed this was typical of daily staffing levels. We were told this was in line with the provider's procedure for determining safe staffing levels on the adolescent unit. Medical care was provided on a 24 hour basis. A doctor was always available in the hospital, including in the evenings and at weekends.

Senior staff told us that extra staff could be brought in to cover staff absence and when patient's needs required it. Regular 'bank' staff, who already knew patients, were used where possible rather than relying on agency staff who did not know patients. More permanent staff were being recruited.

Staff we spoke with showed they understood the care and treatment needs of patients and knew how to meet those needs. They underwent regular training which refreshed their skills and ensured they were able to continue to provide an appropriate standard of care and treatment.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

Patients, their representatives and staff were asked for their views about their care and support. We saw copies of annual satisfaction surveys completed by patients. These showed that the majority of patients were satisfied with their care and treatment. For example, comments from patients on the adult ward and those taking part in the addictions treatment programme included "I felt safe, secure and cared for" and "very caring and committed staff." A report of patient satisfaction on the adolescent unit over the last 12 months showed an improving picture. Overall satisfaction with the child and adolescent service in the first quarter of 2013 was 95% and the total average happiness of patients was 66%.

Feedback received from people was acted upon. Staff provided examples of changes made to patient care in response to suggestions and comments. For example, arrangements for eating meals for the adolescent ward had been changed in response to requests from the young people. Minutes of community meetings held with patients and staff showed that issues raised by patients were followed up by staff. Patients received feedback in relation to their requests for changes.

There was evidence that learning from incidents and complaints took place and appropriate changes were implemented. Staff provided examples of this including changes made after several patients absconded from the adolescent unit, aimed at preventing a reoccurrence.

There was a system in place to identify, assess and manage risks to patients. A programme of audits was carried out throughout the year to ensure that policies were being implemented and risks to patients were managed effectively. For example, a ligature audit of all patient areas and bedrooms had been completed in December 2012. Subsequently action was taken to address identified risks and make bedrooms safer.

However, the provider may wish to note that systems in place to ensure that patient's care plans and risk assessments were regularly reviewed and kept up to date were not always effective. Several care plans we saw had not been reviewed by the specified date. We discussed this with the registered manager who agreed the system of oversight of care

plans needed to be made clear when the adolescent ward manager was on leave.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints were responded to appropriately.

Reasons for our judgement

There was a complaints policy in place which stated clear time frames for the registered manager to respond to a complaint. If complainants were not satisfied with attempts to resolve their complaint this was referred to the provider.

Patients were made aware of the complaints system. This was provided in a format that met their needs. A child and parent guide explaining how to make complaint or a suggestion was available on the adolescent unit.

Patients had their comments and complaints listened to and acted on. The service manager provided examples of how changes had been made to the service in response to comments and suggestions.

Patient's complaints were fully investigated and resolved, where possible, to their satisfaction. Senior managers explained to us how complaints had been investigated and responded to. Face to face meetings were offered to complainants so that they could discuss their concerns directly with senior managers.

An independent advocate was available and could be contacted to help support patients to make a complaint, if they needed assistance.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records in respect of their needs and legal status. Records could not always be located promptly when required. Regulation 20(1)(a)(b)(2)(a)

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Patient records were kept securely. In-patient records were stored electronically and could be accessed by clinical staff using a password.

We reviewed the health care records of seven patients admitted to the adolescent ward and found these were not always accurate. Records contained information about the assessment of patients' needs and the care and treatment provided to them. However, the information recorded in patient's electronic files sometimes conflicted with information given to staff about their care needs and status. For example, the electronic record of one patient on the adolescent unit stated they were detained in hospital under a section of the Mental Health Act 1983. In contrast to this the white board in the staff office, displaying key information for staff about patients, recorded the patient's status as informal. Staff confirmed that the patient was no longer being detained under a section but had been unable to change their status on the system.

In addition, one patient's electronic record stated that they should be observed by staff every 15 minutes. However, the white board in the staff office stated that they should be observed every 30 minutes. When we asked staff about this they said the level of observation had changed but the patient's electronic record had not been updated accordingly. The patient's record was therefore inaccurate. As a result there was a risk that patients would be provided with unsafe or inappropriate care and treatment arising from a lack of consistent and accurate information in records of their care needs.

Records could not always be located promptly. We asked whether we could see the completed capacity assessment for a particular patient. However, staff were unable to locate this on the day of our inspection. They found a note in the patient's record saying the patient did not have capacity but could not find a record of the detailed capacity assessment, explanation of how the clinician had come to this conclusion and in relation to what specific areas the patient did not have capacity. Information in respect of the patient's

capacity to give consent to treatment was not immediately available to staff which meant that the patient was not being protected against the risks of receiving unsafe or unlawful care and treatment. The hospital later provided a copy of a detailed capacity assessment to us confirming the patient lacked capacity. The report was dated 19 April 2013, the day after our inspection.

We asked to see evidence that staff had made a second attempt to explain to a patient their rights under the Mental Health Act 1983. Staff found a note in the ward diary stating this had been done but could not locate a record in the patient's health care notes that could confirm this. Records in respect of each patient were not always accurate or could not be located promptly.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not taken proper steps to ensure patients were protected against the risks of receiving inappropriate or unsafe care and treatment. Assessments of patient's needs were not always reviewed by specified dates and there was a risk that patient's individual needs were not being met and their welfare and safety was not ensured. Regulation 9(1)(a)(b)(i)(ii)
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Patients were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records in respect of their needs and legal status. Records could not always be located promptly when required. Regulation 20(1)(a)(b)(2)(a)

This section is primarily information for the provider

injury	

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 by 29 May 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – 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.

Moderate impact – 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.

Major impact – 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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