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

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Records	✓ Met this standard

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

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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

We carried out this inspection to check whether The Priory Hospital North London had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Records

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 25 February 2014, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

We undertook this inspection to check whether improvements had been made since our last inspection in April 2013. At the inspection in April 2013 we found many care plans had not been reviewed within expected timescale and there was a risk that care plans did not address patients' current needs. In addition, information recorded in patients' electronic records sometimes conflicted with information given to staff about their care needs and status under the Mental Health Act 1983.

At this inspection we found that improvements had been made. We reviewed the health care records of eight young people admitted to the adolescent unit and found that most care plans and risk assessments were up to date and had been reviewed in accordance with specified dates. This ensured care plans reflected the current needs of patients. Patient records were accurate and fit for purpose.

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

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

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

At our last inspection we found many young people's care plans had not been reviewed within expected timescales and there was a risk that care plans did not address patients' current needs.

At the current inspection we found that significant improvement had been made. We reviewed the records of eight young people who were patients on the adolescent unit in the hospital. Seven of the eight young people had individual care plans in place which addressed their needs and were in line with the risks identified. Most care plans had been reviewed regularly by staff in line with timescales identified or when a young person's circumstances changed. There was evidence throughout the care plans that young people were involved in planning their care and many had recorded their comments on the plan. This helped ensure that the needs of the young people were met.

We found the care plans for one young person included a 72 hour care plan put in place on their admission to the unit on 15 February 2014, 10 days before our inspection. However, further care plans had not yet been developed, although the need for plans to address concerns in relation to deliberate self-harm and food and fluid intake had been identified at a multi-disciplinary team meeting on 18 February 2014. We discussed this with the registered manager of the service and senior ward staff. They explained this had been overlooked as the young person's primary nurse was on leave. They told us they would look at improving the system in place by identifying a second staff member to work with the young person so that care plans were developed promptly, even when the primary nurse was on leave.

We noted that care plans were personalised, detailed and written in a way that young people could understand. They gave detailed guidance to staff about the care and support patients needed. Risk assessments had been carried out for all young people and were reviewed in weekly multi-disciplinary team meetings. Plans were in place to manage the risks identified so as to ensure the needs of the young people were met and they remained safe.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

At the last inspection of the service in April 2013 we found that information recorded in patients' electronic records sometimes conflicted with information given to staff about patients' care needs and status under the Mental Health Act 1983. This meant patients were not being protected against the risks of receiving unsafe or unlawful care and treatment.

At this follow up inspection we found that improvements had been made. Patient records including medical records were accurate and fit for purpose. We reviewed the healthcare records of eight young people admitted to the adolescent unit. We found that information recorded in patients' electronic files was consistent with information recorded on the white board in the staff office. This included information about the young person's legal status under the Mental Health Act 1983, showing whether they were informal or detained. The frequency of observations and checks staff were required to make in order to ensure the young people were safe was also consistent. This ensured staff had up to date information about the needs and rights of the young people admitted to the unit.

Records were kept securely and could be located promptly when needed. Most records we asked to see were provided promptly. Electronic records were password protected so that they could be seen and added to by authorised staff only.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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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