Priory Healthcare Limited

The Priory Hospital North London

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Not inspected
Are services safe?	Good
Are services well-led?	Insufficient evidence to rate

Summary of findings

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Not inspected	Our rating of the acute wards for adults of a working age and psychiatric intensive care units stayed the same. We rated safe as good because: The hospital had made progress in addressing the concerns identified at previous inspections. The provider had reviewed the blanket practice of searching all patients' bedrooms twice per month and had implemented a best practice approach based on the risk level of the patient. There were low levels of use of restraint, prone restraint and rapid tranquilization. The clinical rational for any change in a patients' risks was clearly documented. Managers and staff had a good understanding of the risks and pressures on the wards. The managers of the wards and clinical directors held a daily flash meeting every day to get an overview of the daily concerns for each ward, so these could be addressed. The wards were safe, clean and well maintained. However: We found that registered nurse vacancies were still quite high, particularly on Oak Ward. The hospital had a new director who had put in place recruitment plans, however not enough time had passed to see the effect of these. The staff undertook calibration checks on the blood glucose machines, but on Lower Court Ward these were not recorded. Managers implemented a system to record the checks following the inspection. We found several issues with the environment on Oak Ward. The dining room was outside the ward and the ward had little free space. Patients were smoking in the garden on the ward. Managers had plans to decorate the ward and stop smoking in the garden. Lower Court and Oak Ward had gender mixing on the wards. Although male and female patients had separate corridors, there was not a permanent structure separating them.

Summary of findings

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Summary of this inspection

Background to The Priory Hospital North London

We carried out this focused inspection because we received information giving us concerns about the safety and quality of the services. In December 2021 a patient, who was not detained under the Mental Health Act, was found dead after leaving the hospital whilst being cared for on Lower Court.

Due to the COVID-19 pandemic we announced the inspection the day before we visited.

In this inspection, we inspected and rated the Safe key question. We also reviewed parts of the Well-led key question.

We inspected the two acute wards for adults of working age: Lower Court and Oak Ward.

Oak ward is a 14 bed ward for both males and females. The ward provides care to patients from the local NHS mental health trust. This ward had become an acute ward for adults of a working age since we last inspected.

Lower Court is a 28 bed ward. The ward provides care for male and female adults with acute mental health problems, obsessional disorders and substance misuse problems.

There was a registered manager in post.

We last inspected Priory Hospital North London in October 2019. At that time we rated the hospital as requires improvement for safe, and good for effective, caring, responsive and well-led. We rated the hospital as good overall. We rated the acute wards for adults of a working age and psychiatric intensive care units as good for safe, effective, caring, responsive, well-led and overall.

Following this inspection, we issued a requirement notice on the provider concerning Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This action related to the child and adolescent mental health services provided at the hospital.

Priory Hospital North London is registered to provide the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury.

How we carried out this inspection

During the inspection, the inspection team:

- conducted a review of the environment of the clinic room for each ward
- spoke with the hospital director and the clinical services director
- spoke with two ward managers
- spoke with 11 other members of staff including: two registered mental health nurses, five health care assistants, one support services manager, one ward doctor and one occupational therapy assistant

Summary of this inspection

- spoke to six patients
- looked at four medication charts
- looked at ten patient records
- observed a daily meeting
- reviewed other documents related to the running of the service

Outstanding practice

No areas of outstanding practice identified.

Areas for improvement

Action the trust Should take to improve:

- The provider should continue with current recruitment plans and try new approaches to recruit permanent staff to reduce vacancy levels
- The provider should reintroduce the smoke-free policy and continue to promote smoking cessation
- The provider should ensure they have assurance that blood glucose machines are calibrated
- The provider should work towards good practice for same-sex accommodation by implementing a solid wall with a door
- The provider should continue to improve the Oak Ward environment so that it is fit for purpose.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Not inspected	Not inspected	Not inspected	Insufficient evidence to rate	Not inspected
Overall	Good	Not inspected	Not inspected	Not inspected	Insufficient evidence to rate	Not inspected

Acute wards for adults of working age and psychiatric intensive care units

Safe	Good
Well-led	Insufficient evidence to rate

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as safe.

Safe and clean care environments

Lower Court Ward was safe, clean well equipped, well furnished, well maintained and fit for purpose. Oak Ward was a difficult environment for staff to keep safe and needed decoration. However, it was safe, clean, well maintained and well equipped.

Safety of the ward layout

Oak Ward was very cramped, with little space. Patients there had to use a dining facility outside the ward, which they reached via an uncovered pathway. Staff had to escort patients off the ward to access the dining room. This presented additional risks that the staff managed through risk assessment and observation of the patients. The windows in the bedrooms were not easily operated and the fencing in the garden was low and easily scaled. The hospital director told us that there had been a successful bid for refurbishment of Oak Ward and that work would commence to improve the environment.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. All rooms on Oak Ward had anti-barricade doors, and all bedrooms had ensuite facilities across both wards.

Staff were not able to observe patients in all parts of Lower Court and Oak Ward easily, due to the shape and layout of the wards. However, convex mirrors had been installed to cover blind spots. On Lower Court Ward there were two nurses' stations, staff risk assessed patients on admission, and patients with higher levels of risk were put in the 'safer' rooms nearer to the nurse's stations. The communal spaces on the ward were covered by CCTV.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff had completed an environmental ligature risk audit for both wards. This identified how to mitigate risks. Staff received an induction to the risks on the ward when they first arrived. Ligature cutters were stored in the ward offices.

The ward complied with guidance around mixed sex accommodation, although some staff and patients told us that the current arrangement was difficult to manage. The wards were mixed sex wards, however, this was mitigated by having the male and female corridors separated. Best practice guidance for mixed sex wards states there should be a solid wall with a door that can lock to separate male and female areas. Some staff and patients told us that arguments would still occur due to the mixing of genders on the ward.

Acute wards for adults of working age and psychiatric intensive care units

On Lower Court Ward there was a nurse's station separating the male and female corridor and male patients had no need to cross female only corridors. On Oak Ward we were told there was a staff member positioned in the open corridor. Both wards had a female only lounge and all bedrooms had ensuite bathrooms.

Staff had easy access to personal alarms and patients had easy access to nurse call buttons in their bedrooms. Staff were given a personal alarm each shift upon signing onto shift.

There was no seclusion room present in either Lower Court or Oak Ward.

Oak ward had a de-escalation room. This room was an old bedroom and had a large bean bag in it. Staff told us that they used the room to calm patients and talk with them. No patient would be in the room on their own. The ward manager told us that they planned to develop a new room with a better environment.

The hospital had a no smoking policy in line with national institute for health and care excellence and NHS England, however patients were smoking in the garden on Oak ward which contravened this policy and the guidelines. The clinical services director told us that this was reintroduced during the Covid-19 pandemic and they planned to become a non-smoking ward again on the 1 March 2022. Patients could access smoking cessation support and nicotine replacement treatment.

Maintenance, cleanliness and infection control

Ward areas were clean and well maintained. Lower Court Ward was well furnished and fit for purpose, but Oak Ward had little space and needed refurbishment. Managers planned to refurbish the ward. Staff completed annual infection prevention and control audits and carried out action plans as a result of these, for example replacing a faulty fridge in the clinic room. The wards were clean and cleaning records had been completed.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Clinic room audits were reviewed by the ward managers each week. Ward managers identified gaps and formed actions to address them.

On Oak Ward the blood glucose machines were calibrated daily and checks were kept by ward staff and checked by the ward manager. On Lower Court Ward, staff told us that the blood glucose machines were calibrated weekly; but there were no records kept of these checks and the ward manager was unable to confirm that these calibrations took place.

Staff checked, maintained, and cleaned equipment. The clinic rooms in both wards and the examination room on Oak ward were clean, and cleaning schedules were completed and up to date. Both wards had emergency resuscitation bags available, which staff checked.

Safe staffing

The service had ongoing issues of not having enough permanent nursing staff to fill the shifts. However most shifts were covered by agency and bank staff who received training to keep people safe from avoidable harm. The service had enough medical staff who knew the patients.

Acute wards for adults of working age and psychiatric intensive care units

Nursing staff

The wards had high numbers of vacancies, but the provider ensured that most were covered by agency and bank staff.

Lower Court ward reported an overall vacancy rate for registered nurses of 38.6% as of 9 February 2022. Oak ward reported an overall vacancy rate for registered nurses of 70.5% as of 9 February 2022.

On Lower Court Ward the ward returns showed that most shifts were filled. The ward assigned two to three registered nurses and four support workers for the day shift and two registered nurses and two support workers for the night shift. In the last two weeks there had been two shifts at night that only had one registered nurse. On one of those shifts the other wards supported due to not being able to find staff to fill in. The other shift had an extra support worker to cover.

On Oak Ward the ward returns showed that most shifts were filled, although the ward manager had to be in the numbers to achieve this sometimes. The ward assigned two registered nurses and three support workers for the day shift and two registered nurses and two support workers for the night shift.

In the last two weeks there had been three shifts at night that only had one registered nurse. All three of these shifts had extra support workers to cover. Three agency registered nurses used by the service had worked at the hospital a long time and received supervision.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients told us they felt safe on the wards.

The hospital director and clinical services director told us that the provider was undertaking several recruitment strategies. This included a retention bonus and Christmas bonus for permanent staff to encourage agency and bank staff to apply for permanent roles. The ward managers told us there had already been interest from staff to become permanent as a result of this. The hospital director had received approval to offer three month locum contracts with higher rates of pay, as well as an increase in salary for permanent staff.

At daily flash meetings which were attended by ward managers and directors, staff discussed staffing for the day for each ward and were able to share staff across the wards if one ward had extra staff and another ward needed cover, for example if a staff member said they could work an extra shift but were not needed on their ward, they could be moved to another ward for that shift. The ward managers had both been working for this hospital for over five years. Staff shared information at handovers to keep patients safe.

Where bank or agency staff were used, they received a full induction. The induction checklist included the environmental risks on the ward, including potential ligature anchor points. Staff told us they felt they could carry out physical interventions safely.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. Lower Court had a full-time ward doctor, with a resident medical officer to cover nights and weekends, and visiting consultants. Oak Ward had a locum consultant and was covered by the hospital medical director. Managers could call locums when they needed additional medical cover.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Overall compliance for permanent and bank staff with mandatory training was 95% as of 9 February 2022.

The mandatory training programme was comprehensive and met the needs of patients and staff. The programme included courses on patient safety, security, prevention and management of violence and aggression, basic life support with defibrillator and immediate life support, and reducing restrictive intervention training. Bank and agency staff did a full induction before starting. Locum staff completed safeguarding and prevention and management of violence and aggression training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behavior. As a result, staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission and discharge, using a recognized risk assessment tool, and reviewed this regularly, including after any incident. The risk assessments were reviewed with the medical team. The ward admitted patients experiencing psychiatric disorders including depression, anxiety, stress, obsessive compulsive disorder, body dysmorphic disorder and post-traumatic stress disorder. Patients typically presented risks of self-harm, suicidal ideation and risks to others. During the inspection we reviewed the risk assessments and risk management plans for ten patients.

All records had a risk assessment at admission, and any change in patients' potential risks had the clinical rationale clearly documented. The risk assessments had observation levels clearly stated with the rationale recorded. The observation sheets completed by staff matched with the care records. Staff completed these in full with no gaps. Incidents on observation sheets were recorded and updated on the risk assessment and care plans.

Management of patient risk

Staff discussed patient risk at handovers and recorded this clearly. Staff told us they found the handovers useful. Staff identified and responded to any changes in risks to, or posed by, patients.

Staff updated most risk assessments and plans following incidents. Information needed to deliver patient care was available to all relevant staff, including agency staff, when they needed it and was in an accessible form. However, when reviewing patient records, we found one instance where a recent incident had not been added to the patient's risk assessment. The risk assessment for the day stated the patient had no plans to harm themselves, however the daily care record stated the patient had been using a pen and punching walls. Later that afternoon there was an incident reported that the patient had self-harmed with the pen. The incident from the daily care records had not been added to the patients' risk assessment.

Patients were assessed against a five-point risk assessment form when leaving and returning to the wards. The five points included their mental state, relational security, medication compliance, section 17 status (if applicable) and whether there had been any significant self-harming or aggressive behavior in the last 24 hours.

Staff were not able to observe patients in all parts of the wards. Convex mirrors had been installed to cover blind spots, and communal areas were covered by CCTV. When patients presented with a heightened level of risk they were put in the 'safer' rooms nearer to the nurse's stations, and staff would adjust their level of observations based on the patient's level of risk.

Staff followed policies when they needed to search patients or their bedrooms and used a best interest approach based on the patient's level of risk. This meant that the frequency of searches was assessed against a patient's level of risk, for example, for self-harm or bringing contraband onto the ward.

On Lower Court Ward informal patients were encouraged to show staff their bags and pockets when returning to the ward. There was a cupboard for restricted items, and staff monitored when patients signed these items in and out and when the patients were using them. Following an incident where a patient was found dead after leaving the hospital whilst being cared for on Lower Court Ward staff undertook random room searches. Staff would also search a patient's room based on their level of risk, or if they had visitors. When patients were admitted onto the ward, they were not able to access their room until their property was searched and banned items explained to them.

Use of restrictive interventions

Levels of restrictive interventions were low across both wards. On Lower Court Ward there had been one instance of intramuscular rapid tranquilization in the last 12 months. None of the patients on Oak ward during the inspection had received intramuscular rapid tranquillization.

Staff made every attempt to avoid using restraint by using de-escalation techniques, such as talking with them or having the patient smell essential oils. Staff told us that they only restrained patients only when these failed and when necessary to keep the patient or others safe.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognize and report abuse, appropriate for their role. Safeguarding information was displayed in the office and on the wards. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff kept up-to-date with their safeguarding training.

Staff could give examples of how they identified and recognized abuse, and how they reported this. Safeguarding concerns reported by staff included financial, physical and sexual abuse.

Staff followed clear procedures to keep children visiting the ward safe. Rooms were available for use outside the wards for patients meeting with children.

On Lower Court Ward the safeguarding lead was the deputy ward manager.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to most clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. All clinical staff had access to the electronic patient note storage system. Most notes were electronic. Some exceptions included the sign in and out sheet on Lower Court ward that monitored when patients left and returned to the ward, and physical health observations following use of rapid tranquilization.

On Oak Ward, where patients were placed by the local NHS mental health trust, staff had could access the patients' NHS records using a laptop provided by the trust.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were stored securely in cabinets and a medicines fridge and were disposed of safely.

Lower Court Ward stored controlled drugs. A pharmacist would visit weekly to dispose of any controlled drugs. Records of the storage and administration of controlled drugs were kept on each ward.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. Controlled drugs were stored in the Lower Court clinic room. Record books were completed and correct. Medicine refrigerator and clinic room temperatures were checked and recorded to ensure medicines were stored at a temperature where they remained effective. Fridge temperature records showed that in January 2022 not all days had the temperature checked, however ward managers had oversight of this and addressed this through audits.

Blood glucose machines were calibrated daily on Oak Ward and weekly on Lower Court Ward by ward staff in line with manufacturer's instructions. On Oak Ward daily calibration checks were kept by ward staff and checked by ward manager. However on Lower Court Ward no records were kept of the calibration so managers had no assurance that this was being done. The provider has told us that since the inspection Lower Court Ward have put in place a process where this is completed daily.

Staff reviewed the effects of each patient's medicines on their physical health according to national institute for health and care excellence guidance.

Track record on safety

The service was taking action to improve patient safety on the wards.

In the last 12 months, there were two serious incidents on Lower Court and none on Oak Ward.

In December 2021 a patient, who was not detained under the Mental Health Act, was found dead after leaving the hospital whilst being cared for on Lower Court.

The Lower Court Ward ward manager immediately arranged for an extra staff member to be designated security to monitor all patients as they left and returned to the ward and arranged for all staff performing observations to complete competencies. They took disciplinary action against staff involved where necessary.

Acute wards for adults of working age and psychiatric intensive care units

In March 2021 a patient became violent towards their family members outside the hospital building on hospital grounds. Staff intervened and restrained the patient. Learning from this incident included a better understanding of individual patient triggers, how to identify and monitor them.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

We reviewed the electronic incident reporting record system and spoke to the two ward managers. Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy.

Managers held huddles for staff after any serious incident. Psychology debrief sessions were offered to all staff following a recent serious incident. Managers investigated incidents in a timely manner and shared lessons and outcomes at team meetings.

There was evidence that changes had been made as a result of feedback. Following the recent serious incident on Lower Court in which a patient had died after leaving the hospital, the service immediately instated an extra staff member at the entrance to record patients that left and returned to the ward.

Is the service well-led?

Insufficient evidence to rate

We did not re-rate well-led.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff told us they commended the managers and directors of the hospital. The senior management team included a new hospital director and clinical services director. The senior management team had a good understanding of the challenges to the service, and they had plans in place to address these. For example, to address the low staffing difficulties the hospital director had received approval to increase salaries and offer retention and Christmas bonuses. Staff spoke highly of the new management, and they felt positive regarding plans in place to address service issues and could feel the impact.

The staff and ward managers told us the senior management team were visible and approachable. Leaders in the service could describe how staff were working to provide safe, high quality care. Development opportunities were available for staff in the service.

Culture

Staff felt respected, supported and valued. They were positive regarding the new hospital director and new clinical services director. The ward managers had both worked for this hospital for over five years.

The staff there were opportunities for development and career progression. The director of clinical services was to go on maternity leave shortly and told us they hoped to develop staff from within the team to cover that position. They were also looking to create additional senior roles such as a night shift coordinator.

The hospital director had initiated a retention bonus and a Christmas bonus to retain staff and boost morale. This was only available to permanent staff. They had made a successful business case to raise registered nursing salaries to make them more competitive and implemented this. Staff told us they appreciated this.

Staff told us they could raise any concerns without fear.

Governance

The provider had effective systems in place to measure the performance of the service. The governance system for the service had been reviewed and changed since the new hospital director started. The clinical governance format now comprised of subcommittees that report to the hospital-wide clinical governance meeting. These subcommittees reviewed a wide range of quality and safety information including meeting minutes, infection control audits, incident reports and complaints.

There were team meetings and senior management team meetings. This ensured incidents, complaints, safeguarding referrals and learning from investigations were shared with staff. Staff have monthly team meetings where patient risks and learning from incidents were discussed. There were regular audits completed on the ward, such as for the clinic rooms and ligature risks. These were reviewed by the ward managers. Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The hospital had a risk register which outlined the current risks in the service. The highest risks at time of inspection were the registered nursing vacancies, the public's access to hospital grounds to access public parks, and the Covid-19 variant Omicron. These risks reflected those we found during the inspection and reported by staff. Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Following a serious incident in December 2021 staff competencies were updated for the wards. The senior management team attended the debrief call for this incident to be visible to staff.

'Flash' meetings were held every weekday morning. These involved ward and senior managers. The purpose of these meetings was so that senior managers were aware of any difficulties, such as staffing issues or clinical situations, so that they could steps to minimize them.

When performance issues had been raised the management, team took action to address these. This included suspending staff when necessary for an investigation to take place.