Priory Hospital Woking

Quality Report

Priory Hospital Woking
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

This was a focused inspection carried out as a result of concerns raised during a recent Mental Health Act monitoring visit. These concerns raised were about the use of the Mental Health Act (MHA), the use of the Mental Capacity Act and management of environmental risks and individual patients' risks. We therefore focused on these areas in our focused inspection.

- Staff did not follow all the hospital's policies and processes when they assessed and managed risks to patients. This meant that staff did not ensure that risks for patients with complex physical health conditions and risks that patients might harm themselves with ligatures were not always fully mitigated.
- There was insufficient support and resources allocated to the administration of the MHA (we have raised this previously with the provider) which meant the hospital risked acting in breach of the Mental Health Act 1983 and its Code of Practice. The administrator was given insufficient time and training to ensure that all MHA documentation was correct. This meant that there was a risk that patients could be unlawfully detained or treated.
- Staff did not comply with the Mental Capacity Act 2005. Staff did not assess and record capacity clearly for patients who might have impaired mental capacity. Staff did not ensure that best interests decision-making was in place for all patients who might have impaired mental capacity. This meant that the hospital could not ensure that all patients who might have impaired mental capacity had appropriate support to make decisions where they were able to do

Summary of findings

so. The hospital could also not ensure that all decisions made on behalf of patients who might have impaired mental capacity were made in the patients' best interests.

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		This was a focused inspection carried out as a result of concerns raised during a recent Mental Health Act monitoring visit. These concerns raised were about the use of the Mental Health Act (MHA), the use of the Mental Capacity Act and management of environmental risks and individual patients' risks. We therefore focused on these areas in our focused inspection. • Staff did not follow all the hospital's policies and processes when they assessed and managed risks to patients. This meant that staff did not ensure that risks for patients with complex physical health conditions and risks that patients might harm themselves with ligatures were not always fully mitigated. • There was insufficient support and resources allocated to the administration of the MHA (we have raised this previously with the provider) which meant the hospital risked acting in breach of the Mental Health Act 1983 and its Code of Practice. The administrator was given insufficient time and training to ensure that all MHA documentation was correct. This meant that there was a risk that patients could be unlawfully detained or treated. • Staff did not comply with the Mental Capacity Act 2005. Staff did not assess and record capacity clearly for patients who might have impaired mental capacity. Staff did not ensure that best interests decision-making was in place for all patients who might have impaired mental capacity. This meant that the hospital could not ensure that all patients who might have impaired mental capacity had appropriate support to make decisions where they were able to do so. The hospital could also not ensure that all decisions made on behalf of patients who might have impaired mental capacity were made in the patients' best interests.

Summary of findings

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Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Our inspection team

The team was comprised of an inspection manager, a Mental Health Act reviewer and an inspector.

Why we carried out this inspection

We carried out this focused inspection as a result of concerns raised during a recent Mental Health Act monitoring visit. These concerns raised were about the use of the Mental Health Act, the use of the Mental Capacity Act and management of environmental risks and individual patients' risks. We therefore focused on these areas in our focused inspection.

How we carried out this inspection

In this focused inspection we looked at two key lines of enquiry:

- Is it safe?
- Is it effective?

During the inspection visit, the inspection team:

- visited both wards at the hospital
- looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with the clinical services manager
- spoke with six other staff members; including doctors, nurses and health care assistants
- looked at 11 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Priory Hospital Woking

The Priory Hospital Woking provides an acute inpatient service and an inpatient substance misuse treatment programme for men and women of working age.

It has 35 rooms for patients across two gender specific wards. Cedar ward has 18 beds for men and Maple ward has 17 beds for women. There was one corridor of four beds which could become part of the male or female ward dependent on the gender mix required at the hospital at any time. At the time of our inspection there were 27 patients receiving treatment.

The hospital has an acute treatment programme for a range of conditions which include depression, stress and anxiety.

The hospital provides a treatment programme for patients with addiction issues with substances and behaviour and provides medically assisted detoxification to patients who require this.

Patients who have completed the 28-day addictions programme at the hospital can access up to 12 months of follow-up care. The day programme also provides an individual or group therapy programme to people who have not been inpatients but have been referred to the programme by a consultant psychiatrist.

The Priory Hospital Woking was last inspected on 17-18 April 2018. This was an unannounced comprehensive inspection and the hospital was rated as Good overall and Good in all five key lines of enquiry.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff were not recording patients' ligature risks in their risk assessments which meant that the rationale for the allocation of rooms to patients on admission based upon risk was not clear.
- Staff were not recording the rationale for why patients' risks were downgraded from high or medium to low which meant that patients' clinical records lacked important information.
- The provider was not recording and describing risks for all patients with complex physical healthcare conditions. This meant that staff did not have complete information to meet the patients' physical healthcare needs.

However:

- All areas of the hospital were clean and well maintained. The cleaning schedules were thorough and carried out effectively.
- Staff vacancies were covered by regular locum staff who had completed mandatory training and an induction to the wards.
- Staff were confident in recognising and reporting safeguarding concerns and the progress of concerns was monitored by the hospital safeguarding lead.
- Medicines were safely managed and stored and this was audited regularly.
- Staff reported incidents effectively and these were investigated by managers. Learning outcomes were shared to all staff via the learning from experience reports.

Are services effective?

- There was insufficient support and resources allocated to the administration of the Mental Health Act (MHA) which meant the hospital risked acting in breach of the Mental Health Act 1983 and its Code of Practice. The administrator was given insufficient time and training to ensure that all MHA documentation was correct. This meant that there was a risk that patients could be unlawfully detained or treated.

Summary of this inspection

- Staff did not understand fully their roles and responsibilities under the Mental Health Act 1983 and the MHA Code of Practice. This meant that there was a risk that the hospital could not ensure that patients' care and treatment complied with the MHA and Code of Practice.
- Staff did not ensure that patients were informed of and understood their rights in compliance with the MHA Code of Practice. This meant that there was a risk that patients would not understand their right to appeal their detention.
- The hospital's record-keeping system did not ensure complete and accurate records were kept of patients' detention status. The hospital's processes to scrutinise MHA documents did not ensure that errors in the legal paperwork were identified and corrected. This meant that patients were at risk of being detained without lawful authority.
- Inconsistencies in the recording of patients' capacity to consent to treatment led to risks that patients' treatment authorisation forms were incorrect. This meant that patients were at risk of receiving treatment that was not properly authorised under the MHA.
- Staff did not assess and record capacity clearly for patients who might have impaired mental capacity. This meant that the hospital could not ensure that all patients who might have impaired mental capacity had appropriate support to make decisions where they were able to do so.
- Staff did not ensure that best interests decision-making was in place for all patients who might have impaired mental capacity. This meant the hospital could not ensure that all decisions made on behalf of patients who might have impaired mental capacity were made in the patients' best interests

Are services caring?

We did not inspect this domain as part of this focused inspection.

Are services responsive?

We did not inspect this domain as part of this focused inspection.

Are services well-led?

We did not inspect this domain as part of this focused inspection.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- There was insufficient support and resources allocated to the administration of the MHA which meant the hospital risked acting in breach of the Mental Health Act 1983 and its Code of Practice. The administrator was given insufficient time and training to ensure that all MHA documentation was correct. This meant that there was a risk that patients could be unlawfully detained or treated.
- Staff did not understand fully their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act (MHA) Code of Practice. This meant that there was a risk that the hospital could not ensure that patients' care and treatment complied with the MHA and Code of Practice.
- Staff did not ensure that patients were informed of and understood their rights in compliance with the MHA Code of Practice. This meant that there was a risk that patients would not understand their right to appeal their detention.
- The hospital's record-keeping system did not ensure complete and accurate records were kept of patients' detention status. The hospital's processes to scrutinise MHA documents did not ensure that errors in the legal paperwork were identified and corrected. This meant that patients were at risk of being detained without lawful authority.
- Inconsistencies in the recording of patients' capacity to consent to treatment led to risks that patients' treatment authorisation forms were incorrect. This meant that patients were at risk of receiving treatment that was not properly authorised under the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not assess and record capacity clearly for patients who might have impaired mental capacity. This meant that the hospital could not ensure that all patients who might have impaired mental capacity had appropriate support to make decisions where they were able to do so.
- Staff did not ensure that best interests decision-making was in place for all patients who might have impaired mental capacity. This meant the hospital could not ensure that all decisions made on behalf of patients who might have impaired mental capacity were made in the patients' best interests.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Safe and clean environment

The hospital had 35 beds which were divided in to two gendered wards, Maple ward and Cedar ward. The two wards were spread across a purpose built two-storey wing and partially situated in the older part of the hospital building.

On each ward there were six bedrooms which were part of the new building. These rooms were located in a corridor which housed the nurses' office and were equipped with anti-ligature bathrooms, anti-barricade doors, and door viewing panels. The remaining patient bedrooms, in the older building on each ward, had fewer anti-ligature furniture and fittings, doors without viewing panels and were further away from the nurses' office. There were significant ligature risks in these rooms including door closure brackets, door hinges and other weight bearing fixtures. This meant that these rooms were less suited to patients with higher risks of self-harming.

Staff we spoke with told us that following an assessment of their ligature risks, patients with higher risks were accommodated in the bedrooms with anti-ligature fittings closest to the nurses' office on each ward. This ensured that patients with higher risks could be more easily supported and observed by nursing staff. At the time of inspection, we did not see assessments of patients' ligature risks recorded in the patient notes that we reviewed.

All patient areas had been assessed by staff for ligature risks and staff were aware of the location of high risk areas. The most recent ligature audit had been completed in January 2019. Hospital managers had an action plan of works to reduce the number of ligature risks in the older part of the hospital. This included works to patient bedrooms to improve the standard of anti-ligature fittings and remove the bedroom door closures which were identified as high risk.

All areas of the hospital were clean. There was a comprehensive housekeeping schedule in place and we saw routine cleaning happening during our inspection.

We saw that some of the furniture in the clinic rooms, flooring and general decoration across the hospital, were stained and in need of refreshing. Hospital managers told us that the hospital had a refurbishment plan and had recently appointed a member of staff to begin redecoration.

Each ward had a single sex lounge for male and female patients and this was equipped with board games and a television. Patients could also use a communal lounge area for either male or female patients.

Each ward had a clinic room which was clean and well organised. The clinical equipment was comprehensive and recently tested as required, and fridge temperatures were monitored daily and recorded by staff. A grab bag with emergency medicines was available to respond to medical emergencies. The medicines were safely stored and disposed of.

Safe staffing

There were qualified nurse vacancies at the hospital with 8 registered mental health nurse (RMN) positions vacant. There were three health care assistant (HCA) vacancies. At the time of inspection, the vacant hours were covered by six locum RMNs, bank staff and staff who worked extra hours.

The locum nurses had been working at the hospital for many months. This meant that they had a good knowledge of the patient needs on each ward. All staff in bank or agency roles received a full hospital induction and completed the mandatory training relevant to their role.

The hospital used a staffing ladder to establish the staffing mix dependent on the number of patients on the wards. In the daytime there was a minimum of two qualified nurses and up to three health care assistants on each ward when the ward was full. Staff said that at times when patients required higher levels of observation staffing numbers were stretched.

Medical cover was provided by a ward-based psychiatrist who worked Monday to Friday. Out of hours cover was provided by an onsite doctor who was located at the hospital for a seven-day period to be available to patients and staff. The out of hours doctor assessed patients who were admitted during these times. Staff said that the level of cover was adequate and medical support was available when they needed it.

The hospital managers worked to an on-call rota to provide management advice and support out of hours.

Staff sickness rates at the hospital were low. There was one long term staff sickness which was being managed via the provider's sickness policy.

Staff received mandatory training and completion was monitored on a central record. At the time of inspection completion rates for training were generally good. Mandatory training courses covered infection control, safeguarding, basic life support, safe handling of medicines and fire safety. Over 80% of staff had completed training in the prevention and management of violence and aggression.

The training records we viewed showed that 79% of staff had completed infection control training and 86% had completed basic life support training including the use of a defibrillator. This meant that staff were able to respond effectively to health emergencies.

Assessing and managing risk to patients and staff

We reviewed 11 sets of care records for patients from both wards. There was evidence in all records that risk screening had taken place. Patient risks were recorded for all patients at the point of admission. All patients had a risk assessment in place and we saw that this was being reviewed by staff at regular intervals.

Although there was frequent review of patient risks by the multi-disciplinary team (MDT), in the 11 patient notes that we reviewed there was often no rationale recorded on patient risk assessments why patient risks had been downgraded. This made it difficult to establish what had changed for the patient for their risk levels to move from high or medium to low.

The risks of one patient with complex physical health needs had been discussed at the MDT meeting, but these risks had not been sufficiently recorded in their risk assessment and had not been detailed in their care plan. We informed the manager of this at the time of inspection.

We saw that staff were completing and recording regular observations of patients following the hospital policy. These were carried out at levels set by the hospital doctor and reviewed by the MDT. All newly admitted patients were admitted on general observations, unless risk assessment deemed them to need a higher level of observations. General observations meant a that presence check was done every two hours. This was reviewed at their first meeting with the MDT. Nursing staff could take decisions to increase the frequency of patient observations and levels could be lowered on review by the patient's doctor.

The referral criteria for the hospital excluded patients with a current risk of violence. During working hours newly referred patient risks were screened by a central Priory referral triage team before a decision was made to allocate a bed at the Priory Hospital Woking. This was a new referral system which had been in place for several months. These referrals included patients who were referred from the NHS due to the unavailability of a local NHS acute bed. The number of NHS referrals and the number of detained patients at the hospital had increased in the last six months. This meant that the wards had higher numbers of patients detained under the Mental Health Act than at the time of the previous inspection in 2018.

Safeguarding

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

The staff we spoke with were confident about how to recognise and report safeguarding concerns. A member of the senior team was a lead for safeguarding and maintained contact with the local authority safeguarding team for advice on safeguarding concerns.

We saw a detailed log of safeguarding concerns raised with the local authority safeguarding team was maintained by the hospital to monitor the progress and outcome of investigations.

Staff received annual training in safeguarding adults and safeguarding children. At the time of inspection this training had been completed by 89% and 95% of the staff team respectively.

Staff access to essential information

Patient information was securely stored on an electronic care records system. All staff, including locum nurses, had a log-in for the electronic patient records which included care plans and risk assessments for each patient. They also had access to the electronic incident reporting system so could read and report of any serious events that happened on their shift.

Staff allocated their roles for each shift at the morning handover. These included: patient allocation to individual nurses, key duties such as supporting patients with section 17 leave, patients who required increased levels of observation or assistance with their physical health. This meant staff had clear information regarding their duties on shift.

Medicines management

The service had arrangements in place with a pharmacy provider to support the medicines management process with a weekly visit. The pharmacist completed regular audits and these included the clinic room, controlled drugs and high dose anti-psychotics.

We sampled the medicines charts for several patients which were in good order. We saw that medicines had been prescribed safely and in line with prescribing guidance for their use. There were good arrangements in place with the pharmacy provider to support the medicines management process. The pharmacist completed a monthly audit of the clinic room and fed-back any learning to the hospital managers and attended the hospital governance meeting every three months.

Staff provided patients information and support with their medication. This included guidance regarding side effects and, when required, regular health monitoring.

Track record on safety

There had been five incidents of restraint involving patients in the three months prior to inspection. There had been five incidents of rapid tranquilisation in the last three months. The majority of restraints involved times when staff were restraining a patient to prevent absconsion from the hospital. The hospital did not use prone restraint or train staff in its use.

The hospital had recorded 61 incidents in the three months prior to this inspection. The most frequent reported type of incident in the six months prior to inspection was the absconsion of detained patients or informal patients leaving the hospital site without informing nursing staff, patients self-harming, and aggression involving patients.

The hospital maintained an open entrance but at times when there were increased concerns of patients leaving the hospital without leave an inner door had been fitted to the hospital reception area. Staff could close the inner door based on an assessment of the levels of risk by ward staff, and access was then controlled by a key-pad.

Reporting incidents and learning from when things go wrong

Staff recorded all incidents on the hospital's electronic e-compliance report. These were reviewed and signed off by the clinical services manager and the hospital director.

The staff we spoke with were knowledgeable about the process for recording incidents and felt confident in using the electronic reporting tool.

Staff told us that they received support from peers and debriefing from senior colleagues following a serious incident.

The clinical services manager regularly reviewed incidents at the hospital and circulated a monthly learning from experience report to all staff which detailed the incident, the actions taken and themes emerging.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Adherence to the MHA and the MHA Code of Practice

The hospital historically had few detained patients. However, the number of detained patients had increased in the last two years. On the day of the focused inspection, there were four patients detained under the MHA. The hospital had treated an increasing number of NHS patients from trusts all over the country. The hospital had treated 178 detained patients since 1 January 2018 to the date of the inspection. Patients were often quickly repatriated to their local services but some patients remained longer. We reviewed 33 statutory records for patients who had remained at the service for more than a few weeks.

Patients were confused about the role of the independent mental health advocate (IMHA) and the general advocate commissioned by the hospital. Surrey Advocacy Service was commissioned by the local authority to provide an IMHA. Staff explained to patients their right to see an IMHA. Patients who lacked capacity to self-refer to an IMHA were not referred to the service which does not comply with the MHA Code of Practice. The hospital staff had to contact the IMHA when patients requested to see them. However, the hospital staff did not keep a record when the IMHA responded so the hospital could not confirm that all patients who requested to see an IMHA had been able to do so.

Staff did not ensure that patients were informed of and understood their rights in compliance with the MHA Code of Practice. Whilst records showed that staff explained to patients their rights under the MHA, it was not clear when these were repeated. The form used did not provide an opportunity for staff to record if the patient had understood their rights or not. Some records were incomplete and it was not clear what information the patients had been given. This meant that there was a risk that patients would not understand their right to appeal their detention.

The hospital's record-keeping system did not ensure complete records were kept of patients' detention status. Information about the patient and the section patients were detained under was recorded in the 'red book' which was kept in a nursing office. Much of this information was incomplete and the dates of commencement of detention and expiry dates were often wrong or had been amended. For those detained under section 3 of the MHA it noted the expiry date as exactly six months from the day of the detention. For example, it was recorded one detention period began on 24 February 2018 and expired on 24 August 2018, whereas the detention period legally expired at midnight on 23 August 2018. This could mean that the section was not renewed in time and as a result the patient could be unlawfully detained.

The hospital's processes to scrutinise MHA documents did not ensure that errors in the legal paperwork were identified and corrected. Errors in the legal paperwork can result in a patient being unlawfully detained. One patient's medical recommendation had been incorrectly completed by one doctor. The doctor had incorrectly dated the date of the patient's assessment as two years in advance. The hospital had not identified the error or corrected it. This meant that the patient could have been unlawfully detained from the date of the assessment in November 2018. At the time of our MHA monitoring visit on 2 April 2019 we discussed this with the MHA administrator and the registered manager who agreed to obtain legal advice and discuss this with the patient immediately. At our focused inspection on 9 April 2019 we were told that legal advice had been requested but not yet received. However, the patient had been informed that they had been unlawfully detained. There was no record made that the hospital had considered all options available to them to continue to treat the patient lawfully. The patient had not been given written confirmation of their detention status or their rights when they were told they had been unlawfully detained.

Inconsistencies in the recording of patients' capacity to consent to treatment led to risks that patients' treatment authorisation forms were incorrect. This meant that patients were at risk of receiving treatment that was not properly authorised under the MHA. One patient had a capacity assessment carried out which recorded that they lacked capacity to consent to admission and treatment. However, on the same day the responsible clinician (the doctor who had overall responsibility for the patient's treatment) had completed a treatment authorisation form which authorised treatment on the basis that the patient consented to treatment. There was no explanation recorded why the two records made on the same day contradicted each other.

Another patient had been assessed to lack capacity to consent to treatment on admission. However, after the patient had been detained for three months there had

been no further capacity assessment and the required treatment authorisation form had not been completed. This patient had received treatment for at least four weeks without the required treatment authorisation form in place. This meant they were receiving treatment that was not properly authorised under the MHA.

The MHA administrator had not been fully trained and had been carrying out the role for two and a half years. This meant that there was a risk that patients could be unlawfully detained or treated. At our last inspection in April 2018 we told the provider that they should ensure that sufficient support and resources were allocated to the administration of the MHA. At this inspection we found that there was still insufficient support and resources allocated to the administration of the MHA which meant the hospital risked acting in breach of the Mental Health Act 1983 and its Code of Practice.

Good practice in applying the MCA

Staff did not assess and record capacity clearly for patients who might have impaired mental capacity. There was also no best interests decision-making recorded for patients who might have impaired mental capacity. This meant that the hospital could not ensure that all patients who might have impaired mental capacity had appropriate support to make decisions where they were able to do so. The hospital could also not ensure that all decisions made on behalf of patients who might have impaired mental capacity were made in the patients' best interests.

In four of the 11 patients' records we reviewed the multidisciplinary team's weekly reviews had recorded that the patients might have impaired capacity. However, there were no further capacity assessments carried out to assess formally whether the patients lacked capacity to make certain decisions.

In three of the four cases a doctor had carried out a capacity assessment on admission which recorded the patients had capacity to consent to admission and treatment. However, in the multidisciplinary team's weekly review notes it was recorded that the patients lacked capacity. There were no further formal capacity assessments carried out and no record made to explain the contradiction between the admission paperwork and the multidisciplinary team's records.

In the records of the fourth patient there was no formal capacity assessment recorded for any decision. However, in three of the weekly multidisciplinary team's weekly reviews of the patient's care and treatment it was recorded that the patient's capacity "fluctuated".

In none of the four patients' risk or care plans was there any reference to the fact the patients might have impaired mental capacity. In none of the four patients' care records was any best interests decision-making recorded or any consideration that the patients might need support with decision-making.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

We did not inspect this domain as part of this focused inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

We did not inspect this domain as part of this focused inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

We did not inspect this domain as part of this focused inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that all mitigating action identified in environmental ligature assessments is taken to ensure the health and safety of all patients.

The provider must ensure they have legal authority when they deprive patients of their liberty for the purpose of receive care or treatment.

The provider must ensure that they act in accordance with the Mental Capacity Act 2005.

The provider must ensure that they act in accordance with the Mental Health Act 1983 as amended 2007.

Action the provider SHOULD take to improve

The provider should ensure that the rationale for the downgrading of patient risks is clearly recorded in patients' records.

The provider should ensure that individual risks for patients with complex physical health conditions are assessed and recorded and that management of these risks is included in their care plan.

The provider should ensure all patients' requests to see an independent mental health advocate are actioned.

The provider should ensure that patients are informed of and understand their rights in accordance with the Mental Health Act and Code of Practice.

The provider should ensure they have sufficient resources and support allocated for the administration of the Mental Health Act.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that they took all reasonable actions to mitigate the assessed risks to the health and safety of service users. The provider's environmental ligature point assessment stated that the risks posed by the identified ligature points in the hospital were mitigated by individual risk assessments of all patients. The ligature point assessment stated that patients' individual ligature risk assessments would be used to determine which bedroom patients were placed in according to the ligature point risks identified in each bedroom. We reviewed 11 patients' notes. We identified six patients who had risk assessments which recorded they were at risk of suicide or deliberate self harm. In none of the six patients' records was there any assessment of, or reference to, individual risk assessments for managing each patient's safety in the hospital environment or identifying suitable bedrooms with reference to the environmental ligature risks. This is a breach of regulation 12 (1) (2) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

The hospital failed to ensure they had legal authority when they deprived service users of their liberty for the purpose of receiving care or treatment.

The hospital's processes to scrutinise Mental Health Act documents did not ensure that all patients were lawfully detained. Errors in the legal paperwork for one patient resulted in the patient being unlawfully detained from November 2018 to April 2019.

This is a breach of regulation 13 (5) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure they acted in accordance with the Mental Capacity Act 2005. Staff had recorded in the multidisciplinary team's weekly reviews of four patients that the patients might have impaired capacity. However, there were no further capacity assessments carried out to assess formally whether the patients lacked capacity to make certain decisions. There was no record of best-interests decision-making in place for the four patients. This is a breach of regulation 11 (3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

The provider did not ensure they acted in accordance with the Mental Health Act 1983 as amended 2007.

Patients were at risk of receiving treatment that was not properly authorised under the MHA. One patient had a capacity assessment carried out which recorded that they lacked capacity to consent to admission and treatment. However, on the same day the responsible clinician had completed a treatment authorisation form which authorised treatment on the basis that the patient consented to treatment. There was no explanation recorded why the two records made on the same day contradicted each other.

One patient had been assessed to lack capacity to consent to treatment on admission. However, after the patient had been detained for three months there had been no further capacity assessment and the required treatment authorisation form had not been completed. This patient had received treatment for at least four weeks without the required treatment authorisation form in place. This meant they were receiving treatment that was not properly authorised under the MHA.

This is a breach of regulation 11 (4) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not established and operated systems and processes to ensure they complied with the Mental Health Act 1983 as amended 2007 and the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

There was insufficient support and resources allocated to the administration of the MHA which meant the hospital risked acting in breach of the Mental Health Act 1983 and its Code of Practice.

There were not appropriate systems in place to ensure scrutiny of detained patients' paperwork on admission. There was not suitable record-keeping to ensure staff had accurate information of patients' detention status and dates of detention.

There were not appropriate systems in place to ensure capacity assessments were carried out for patients who might have impaired capacity. There were not appropriate systems in place to ensure best-interests decision-making took place for patients who might have impaired capacity.

This was a breach of regulation 17 (1) (2) (c).