The Priory Hospital Hayes Grove

Quality Report

The Priory Hospital Hayes Grove
Prestons Road
Hayes
Bromley
Kent
BR2 7AS
Tel: 020 8462 7722
Website: www.priorygroup.com/locations/priory-hospital-hayes-grove

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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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

We undertook a focussed inspection to follow up on information of concern received by CQC during July and August 2020. During this inspection, we looked at the core service 'wards for people with a learning disability or autism' which was provided on the Keston Unit. We did not inspect the other core services provided by The Priory Hospital Hayes Grove.

Summary of findings

We identified concerns in relation to the safety, quality and leadership of services as a result of this inspection. We used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and imposed additional conditions on the provider's registration. This meant that the provider needed to make immediate changes to the leadership of the Keston unit, urgently undertake a review of the sexual safety of the patients on the ward, make urgent changes to the way closed-circuit-television (CCTV) cameras were used in patient bedrooms, and make urgent improvements to the provision of therapeutic activity to aid patients in their recovery.

We had previously inspected 'wards for people with a learning disability or autism' in January 2020, where it was rated as inadequate. At that time we used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and placed a condition on the provider's registration. This meant that the provider could not admit patients to the Keston Unit until improvements had been made. This condition remains in force.

At this inspection we inspected aspects of the safe, effective and well-led key questions. We did not re-rate the key questions we inspected. The previous overall rating for this core service of inadequate remains unchanged.

During this inspection we found:

- The ward did not have sufficiently skilled leadership and work to improve the culture of the ward was in its infancy. There was no clear service model and a lack of robust plans to transition to an appropriate service model that supported patients to develop skills to enable them to live within the community.
- The service did not always provide safe care. Sexual safety risks were not adequately identified or managed and the ward remained non-compliant with guidance relating to same-sex accommodation.
- The service did not always promote the privacy and dignity of patients because closed-circuit television (CCTV) cameras had been activated in patient bedrooms without the consent of patients for the purpose of protecting staff against potential allegations of abuse.
- There were not enough therapeutic activities available to patients that aimed to develop their daily living skills, despite the fact most patients were being prepared to be discharged to community settings following a significant amount of time spent in hospital.
- Improvements needed to be made to the quality of staff handover meetings, to minimise the risk of medication errors occurring and to prevent the transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) because some staff did not wear face coverings correctly.
- The service had a track record of struggling to sustain improvements including improvements to therapeutic activity provisions, discharge planning and in ensuring the ward complied with guidance on same-sex accommodation.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	

Summary of findings

Contents

Good

The Priory Hospital Hayes Grove

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to The Priory Hospital Hayes Grove

The Keston Unit is part of the Priory Hospital Hayes Grove. It is a specialised mixed gender unit for adults of working age who have a diagnosis of Autistic Spectrum Disorder (ASD) with psychiatric co-morbidities. The service also admits people with ASD and mild learning disability. The unit had six patients at the time of the inspection.

The provider was registered to provide care for the following 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

The service had a registered manager in place at the time of this inspection.

Our last inspection of the core service wards for people with a learning disability or autism, which is provided on the Keston Unit, took place in January 2020. At the last inspection we rated the wards for people with a learning disability or autism core service as inadequate under the safe, effective and well led domains, and requires improvement under the caring and responsive domains. The core service was therefore rated as inadequate overall.

Our inspection team

Our inspection team comprised three CQC inspectors

Why we carried out this inspection

This was a focused, unannounced inspection looking at the culture, safety and leadership of the service. The CQC carried out this inspection after receiving anonymous whistleblowing concerns and an increase in notifications of safety incidents.

How we carried out this inspection

This was a focussed inspection. During this inspection we asked the following questions:

- Is it safe?
- Is it effective?
- Is it responsive to people's needs?
- Is it well-led?

During the inspection, the inspection team:

- visited the Keston Unit, looked at the quality of the ward environment and observed how staff were caring for patients
- attended a handover meeting for nursing staff
- spoke with two patients who were using the service
- spoke with four sets of relatives of people who were using the service
- spoke with the registered manager, the director of clinical services, the ward manager and the consultant psychiatrist for the ward
- spoke with 12 other staff including nurses, nursing assistants, a doctor, clinical psychologist, occupational therapist, dietician and occupational therapy assistant
- spoke with an independent advocate
- looked at four care and treatment records relating to patients currently using the service

Summary of this inspection

- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We held telephone discussions with two patients.

They reported that there was not enough to do on the ward, particularly when the occupational therapist was not available. Patients said they spent lots of time in their bedrooms and sometimes felt ignored by staff.

Patients also reported that some staff members were more supportive and understanding of their needs than others, and that they were sorry that the clinical psychologist would be leaving soon because the sessions they had with them had been beneficial.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Good	Good	Good	Good	Good	Good

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Inadequate
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Inadequate

Summary of findings

SAFE
Our existing rating of inadequate remains.

•Staff did not safely manage potential sexual safety risks to patients on the ward. One patient had a documented sexual safety risk history, but there was no plan in place to manage or mitigate these potential risks. One patient told us that they did not feel sexually safe on the ward.

•The Keston Unit remained non-compliant with guidance on same-sex accommodation because male and female bedrooms were situated along a single corridor.

•Staff did not do all that was reasonably practicable to prevent the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) because some staff did not wear their face coverings correctly.

•Further improvements were needed to handover meetings. Staff were split into two groups and two concurrent handover meetings took place, posing a risk that important risk information might be missed by some staff. Although a red, amber green (RAG) risk rating system had been developed, this was not used as a framework for discussion during the handover meeting and staff did not collectively decide on changes to patient overall risk categories.

•Required improvements identified at a previous inspection in January 2020 in relation to medicines had not been addressed. Medicines continued to be arranged by stock rather than organised by patient, patient medication records did not contain photographs of patients and temporary and new nursing staff who were unfamiliar with the patients continued to work on the ward. This meant there was an increased risk that medication errors might occur.

However,

•Improvements had been made to the cleanliness of the ward and its clinical equipment.

•Managers investigated incidents and shared lessons learned with the whole team.

•The provider was continuing to recruit to vacant nursing posts. Efforts were made to ensure regular agency staff were used to cover these posts, which meant that they were able to develop therapeutic relationships with the patients.

EFFECTIVE
Our existing rating of inadequate remains.

•There was a lack of therapeutic activity or activity to support the daily living skills of patients, despite the fact many patients were aiming to be discharged to community settings following a lengthy stay in hospital.

•Some nursing staff were unaware of positive support behaviour plans, which meant the provider could not be sure that these were being implemented consistently.

However,

•The clinical psychologist had been fundamental in upskilling the staff team in how best to manage each patients' needs in relation to their autism and in developing positive behaviour support plans for each patient.

Inadequate

Wards for people with learning disabilities or autism

CARING
Our existing rating of requires improvement remains.

We did not inspect this key question on this occasion.

RESPONSIVE
Our existing rating of requires improvement remains.

•The privacy and dignity of patients was not always promoted by staff. Closed-circuit television (CCTV) cameras were in operation in patient bedrooms without their consent.

WELL LED
Our existing rating of inadequate remains.

•Further improvements needed to be made to the culture on the ward. Relatives and staff reported that staff communication needed to improve. We observed some missed opportunities for interaction between patients and staff.

•The quality of the leadership on the ward needed to be improved. There was a lack of experience working with patients living with autism across the ward's multidisciplinary leaders.

•Senior staff were inconsistent about the future service model and there were no clear plans to transition to a new or improved model.

•The service had a track record of failure to sustain improvements.

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Maintenance, cleanliness and infection control

During the last inspection in January 2020 some clinical equipment was not kept clean. In August 2020 we received information from a whistle-blower that stated that equipment was not cleaned after use. However, during this inspection we saw improvement. Clinical equipment was visibly clean. A new system was in place whereby clinical equipment was stored together in one place and checked weekly by nursing staff. Clean stickers were clearly displayed to show when the equipment was last cleaned.

During the last inspection in January 2020 some areas of the ward were unclean, particularly the dining room. We received information from a whistle-blower in August 2020 stating that bathrooms were not kept clean. During this inspection we found that the ward was clean. We toured all communal areas of the ward and looked inside one patient bedroom and en-suite bathroom, both of which were clean. Staff and patients did not report any concerns to us in relation to the cleanliness of the ward during our inspection activities.

Improvements to the general ward environment were still in progress at the time of this inspection. Some works had been delayed because of the ongoing severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic. For example, new lights, further soundproofing and the installation of a sensory room were in the process of being installed. We received information from a whistle-blower in August 2020 stating that the environment was unsafe because radiators were exposed, nails were visible on interior walls and a patient had managed to obtain a loose metal strip from the ward garden. During this inspection we found that these environmental issues had been addressed.

Staff did not do all that was reasonably practicable to prevent the spread of SARS-CoV-2, which remained at

significant risk of transmission during the time of the inspection. We observed three staff members who were not wearing their face masks safely because their noses were exposed.

During the last inspection in January 2020 we identified that further work was needed to ensure the ward complied with same-sex accommodation guidance. The Mental Health Act 1983: Code of Practice (paragraphs 8.25-6) states that all sleeping and bathroom areas should be segregated. Whilst each bedroom had access to en-suite bathroom facilities and a female only lounge was available on the ward, bedrooms continued to be arranged along a single short corridor.

Safe staffing

Nursing staff

During the last inspection in January 2020 there was a high number of temporary staff working on the ward and patients reported that they were unfamiliar with many of the staff. During this inspection some improvements were being made to ensure greater consistency of care. Although agency staff were still required to cover some vacant posts, a greater effort was made to ensure that the same staff were regularly booked. This meant that agency staff could contribute to the weekly staff MDT meeting and develop therapeutic relationships with patients and better understand their individual needs.

During the inspection there were 1.9 WTE nurse and 8.7 WTE nursing assistant vacancies. A recruitment campaign was being undertaken and staff were being interviewed for these posts during the inspection.

Assessing and managing risk to patients and staff

Assessment of patient risk

During this inspection we reviewed four sets of patient care and treatment records. Each patient had risk assessments in place that were reviewed regularly, including after any incidents. Staff discussed patient risk and any changes to patient risk during handover sessions between each shift.

During the last inspection in January 2020 staff handover meetings were not recorded, which meant that important risk information might not have been accurately captured. During this inspection some improvements had been made to handover meetings and staff held detailed discussions about each patient's risk and any changes to their individual risk. However, on the day of the inspection the staff group were split in two and concurrent handover meetings took place in separate rooms. This posed a risk that important patient risk information might not be discussed with the entire staff team. Although a Red, Amber and Green (RAG) rating system was in use and each patient was categorised according to these risk categories, the RAG rating system was not used as a framework for discussion during the handover meeting and the wider staff group were not therefore involved in deciding collectively what each patient's individual risk rating should be.

Management of patient risk

Staff did not safely manage potential sexual safety risks to patients on the ward. The ward did not comply with guidance on same-sex accommodation because male and female bedrooms were situated along the same corridor. One patient reported that they did not feel sexually safe on the ward.

During our review of patient care and treatment records, we identified that one patient had a documented risk history that included inappropriate sexual behaviour that may put others at risk. There was no plan in place to manage or mitigate this to protect other patients from potential sexual safety incidents.

Use of restrictive interventions

Staff had received training in how to manage violence and aggression.

In August 2020 we received feedback from whistle-blowers stating that staff carried out restraint without being trained. During this inspection we found 71% of staff working on the ward had completed training in Prevention and Management of Violence and Aggression (PMVA) in which they learnt restraint techniques. There was an ongoing project being led by the charge nurse to improve training on the ward and the ward manager explained that they ensured PMVA trained staff were working on each shift so that restraints could be carried out safely as needed.

Staff who had undertaken PMVA training were assessed by the trainer for competency with the techniques. Although agency staff were trained in restraint by their agency, they could also attend the provider's PMVA training and competency assessment to help build confidence in safely using restraint techniques if required.

Medicines management

Inadequate

Wards for people with learning disabilities or autism

During the last inspection in January 2020 we identified that medicines were not always managed safely; we identified examples of medicine errors during that inspection. We also identified that medicines were stored by stock, rather than being arranged according to each patient's required medicines. Photographs were not present on patient medication charts. Both these factors increased the risk of medication errors because temporary staff often administered medicines.

During this inspection, although medication records were easily accessible to staff, they did not contain photographs of patients, and medicines continued to be arranged by stock. The risk of potential medication errors, particularly when new or temporary staff were administering medicines, remained.

One patient reported that in recent months they needed to alert agency nurses to the fact they had attempted to administer their medicines in the wrong form on one occasion, and in the wrong dose on a separate occasion. These incidents were not known to staff and we escalated them to leaders during the inspection.

Reporting incidents and learning from when things go wrong

Reported incidents were discussed during multi-disciplinary team meetings and handover meetings. Learning from reported incidents was identified and shared.

In July 2020, a patient tied a ligature whilst concealed by their bedding during two to one enhanced observation. A ligature is something that could be used for the purpose of hanging or strangulation. During the inspection we reviewed this incident and the learning identified from it.

The providers investigation into the incident found that staff had been actively engaged with enhanced observations at the time of the incident. As a result of learning from the incident, staff observing the patient were reminded that the patients head and hands should not be obscured from view. The patients risk assessment and management plan had been updated to reflect this.

All staff had been reminded of the correct protocols for completing enhanced observations. It was also decided that the patient risk management plan should be attached to the observation sheet, so that staff could readily access this during observations. Learning from the incident also identified that staff should position themselves inside the patient's bedroom when providing enhanced observations.

Senior staff also reported that efforts were now being made to ensure enhanced one to one and two to one observations were now undertaken by longstanding staff members who had developed a therapeutic relationship with the patient requiring enhanced observation.

Staff who were present at the time of the incident attended a debrief at the end of their shift. The incident was discussed at subsequent handover meetings and during a multidisciplinary team meeting. However, our discussions with staff showed that there was some variation in their awareness of this incident and the learning from it.

During this inspection, we reviewed the records of patients being nursed with enhanced observations over several weeks. We found that staff had completed records to demonstrate that the required level of observation required by each patient had been provided. The Director of Clinical Services visited the ward regularly to complete spot checks to ensure staff were undertaking the necessary observations required by each patient.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Inadequate

Best practice in treatment and care

There was a lack of therapeutic activity or activity to support the daily living skills of patients, despite the fact many patients were aiming to be discharged to community settings following a lengthy stay in hospital. We first identified a lack of therapeutic activity on the ward in February 2017 and identified that patients spent a long time in their bedrooms during the January 2020 inspection. This continued to be the case at this inspection.

Two patients and two sets of relatives reported that there was not enough for patients to do on the ward, particularly at evenings and weekends when occupational therapy staff were not available. One patient felt that staff did not

generally engage with them enough and often felt forgotten about. Another patient did not like the limited activities that were available and spent most of their time in their bedroom on their personal computer.

Although a therapeutic activity timetable was in place, the activities on offer were very limited and consisted of games, music appreciation, walks, relaxation time and arts and crafts. There were no activities available to support patients to develop their daily living skills. For example, the ward did not have the facilities to enable patients to plan, budget and cook meals. Although occupational therapy staff used the Model of Human Occupation Screening Tool to assess the occupational therapy needs of patients, objectives such as improving social inclusion or improving personal routines were addressed by activities such as walks in the local area.

Recent improvements had been made to the way staff supported individual patients with their autism and associated needs. For example, each patient now had a positive behavioural support plan in place which had been developed by the Clinical Psychologist. These plans detailed how each patient should be supported to stay happy and calm with a focus on how best to communicate, how to manage when the patient becomes worried or anxious, and how to manage challenging behaviours when the patient was in crisis. However, three of the nursing staff we spoke with did not have an awareness of positive behavioural support plans.

Staff reported that their awareness and understanding of autism and how to manage this in relation to each individual patient had improved. The consultant psychiatrist led a weekly multi-disciplinary staff meeting with the clinical psychologist. Staff explained that they had the opportunity to discuss specific patients and how best to manage their needs in relation to autism during these sessions and that the clinical psychologists experience in working with people living with autism was particularly useful during these discussions. All permanent staff had attended training in working with autism.

Are wards for people with learning disabilities or autism caring?

Requires improvement

Start here...

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Requires improvement

The facilities promote recovery, comfort, dignity and confidentiality

Staff did not always promote the privacy and dignity of patients. Closed-circuit television (CCTV) cameras were in operation in patient bedrooms without their consent.

Our interviews with staff showed that there had been a lack of consideration of patients' privacy or dignity when making this decision and staff reported that the primary reason for activating the cameras in two patient bedrooms was to protect staff from potential allegations of abuse.

There had been no consideration of either patients' capacity to consent to this decision, and representatives, including family members or an advocate, had not been involved in a robust best-interest decision process.

Are wards for people with learning disabilities or autism well-led?

Inadequate

Leadership

Improvements needed to be made to the local leadership on the ward. This was recognised by the Hospital Director and Director of Clinical Services. Neither the ward manager nor the ward consultant psychiatrist had a previous background or specialism in learning disabilities or autism. The clinical psychologist had a background in working with

people living with autism and their skillset was described as being invaluable and had enabled other staff members to develop their knowledge of autism in recent months. However, they were due to leave their post in September 2020 and a permanent replacement had not yet been sourced.

Two staff members reported that there was a lack of leadership and overall decision-making on the ward. When we conducted the site visit part of our inspection and subsequently arranged our remote inspection activities, we identified that there was a lack of clear leadership role-modelling on the ward and a general lack of responsiveness to the ongoing inspection activities. Senior leaders had identified that there had been a lack of prompt action to improve staff training compliance and to resolve conflict between staff members on the ward in recent months.

Vision and strategy

Senior staff were inconsistent when asked what the future model of the service was. There was no plan to transition to a new service model or implementation dates. It was unclear how the current patient cohort, the majority of whom had been receiving inpatient care for many years, were being supported to move on to a community setting.

We previously issued the service with a requirement notice following the February 2017 inspection in relation to a lack of discharge planning. At this inspection we identified that improvement had not been sustained because three patients remained at the service who had been admitted many years previously. Clear discharge plans for these patients were not in place. Some senior leaders stated that some patients had been inappropriately accepted to the service in the past, as there was a lack of clear admission and exclusion criteria. Current patients had a very wide range of complex needs including significant mobility needs, eating disorders and behaviours that could challenge, including aggression.

Culture

Although some initial actions had been taken to start to address the staff culture on the ward, further improvements were still needed.

Three separate groups of relatives reported current and ongoing challenges when communicating with staff. For example, one relative had been requesting that staff see to their loved one's dental needs for weeks before any action was taken because staff hadn't passed the message on or followed up on the request. Another relative explained that staff were reluctant to tell the patient that their Section 17 leave had been cancelled and asked the relatives to break the bad news to the patient instead. Senior staff reported that they were aware that relatives were having ongoing difficulties communicating with staff. Three other staff members also reported that communication between staff still needed to improve.

A 'time to talk' survey had been sent to all staff. This survey focussed on leadership support. However, the results were not broken down by ward and an action plan was yet to be developed. The provider's cultural enquiry was therefore in its early stages, despite the fact that staff reported that they did not always feel respected, supported or valued when we last inspected the service in January 2020.

Staff overwhelmingly reported that they were in favour of CCTV cameras being activated in some patient bedrooms because it protected them from potential accusations of abuse whereby, they would feel a sense of blame. This demonstrated that staff prioritised the ability to defend themselves against accusations over the desire to uphold the privacy and dignity of patients as far as possible.

We identified two occasions where staff missed potential opportunities for positive interactions with patients during the inspection. On one occasion a patient was being followed up and down the corridor in silence by a staff member who was conducting one-to-one observations. On another occasion, a patient was waiting in the corridor for their medicines to be prepared in silence for approximately three minutes surrounded by three staff members.

One staff member had not completed the provider's training in working with autism and demonstrated a general lack of understanding of autism, the reasons behind some of the complex patient behaviours and viewed the fact that some patients required additional support in the form of enhanced observations as being a problem for nursing staff.

Some staff did report that the team had recently started working better together. This was because the multi-disciplinary meeting gave them a better insight into each other's roles and responsibilities. Some staff also reported that the 'clique' groups that had existed amongst nursing staff, whereby staff fell into groups that didn't

always get along with each other, had started to break down, especially since some staff members had been moved to work on different wards. One staff member reported that they now felt confident to raise concerns directly with local leaders, but up until recently they felt they had needed to use the provider's anonymous whistleblowing process to raise concern because they were worried they might be victimised.

Learning, continuous improvement and innovation

The provider had a track record of failure to sustain improvements to this service. For example, despite a requirement notice following the February 2017 inspection about a lack of discharge planning we still identified during this inspection that the model of the service was not clear and some patients had been using the service for around ten years.

Despite a requirement notice following the February 2017 inspection about a lack of therapeutic activity we still identified during this inspection that there was a lack of therapeutic activity.

Despite reports following the January 2020 inspection that we had observed a male patient looking into a female patient bedroom and that the bedroom corridor was mixed gender, at this inspection we identified that the ward continued not to comply with guidance on same-sex accommodation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must make immediate improvements to the quality of leadership of the Keston unit. **Regulation 17 (1) (2) (a) (b) (e)**
- The provider must act to ensure patients on the Keston unit are safe from potential incidents relating to sexual safety. **Regulation 12 (1) (2) (a) (b)**
- The provider must review its use of CCTV cameras in patient bedrooms and ensure the correct processes are followed in relation to consent, capacity and best interest decisions. **Regulation 10 (1) (2) (a)**
- The provider must improve the provision of therapeutic activities that support patients to develop their living skills. **Regulation 9 (1) (3) (a) (b)**
- The provider must act to prevent the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) by ensuring all staff wear the appropriate personal protective equipment whilst at work. **Regulation 12 (2) (h)**

Action the provider SHOULD take to improve

- The provider should continue to improve the quality of staff handover meetings.
- The provider should ensure it completes its work to improve the female lounge
- The provider should ensure it does all that is practicable to minimise the risk of medication errors
- The provider should ensure it completes its work to improve the quality of communication between relatives and carers and staff working at the Keston unit.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance