Cygnet Health Care Limited

Cygnet Hospital Godden Green

Quality Report

Godden Green
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Date of inspection visit: 2 and 3 January 2019
Date of publication: 04/04/2019

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-130486742	Cygnet Hospital Godden Green	Cygnet Hospital Godden Green	TN15 0JR

This report describes our judgement of the quality of care provided within this core service by Cygnet Health Care Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cygnet Health Care Limited and these are brought together to inform our overall judgement of Cygnet Health Care Limited.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

Cygnet Hospital Godden Green has an integrated Tier 4 (inpatient wards) child and adolescent mental health service alongside a Department for Education, Ofsted - registered school, the Knole development centre. Its specialist pathway offers an open acute admissions service (Knole ward), and a pre-discharge ward (Littleoaks ward) to allow for a smooth transition for young people returning home to their families.

We last inspected this service in February 2018. This was a planned, announced comprehensive inspection and we rated the service as good overall and good in all domains.

Prior to this, we had undertaken a focussed inspection in November 2017, due to concerns about the safety of young people at the service including the number and severity of incidents and the lack reporting externally to relevant bodies. At this inspection we told the provider it must improve. From this inspection, we found the provider to be in breach of regulation 12, safe care and treatment, regulation 13, safeguarding service users from abuse and improper treatment and regulation 17, good governance. We also issued the provider with fixed penalty notices under sections 87 and 87 of the Social Care Act and Regulation 28 and Schedule 5 of the Health and Social Care Act20118 (Regulated Activities) Regulations 2014. The fixed penalty notices were issued in relation to multiple failures by the provider to make required notifications to the Care Quality Commission.

On the 2 and 3 January 2019, the Care Quality Commission carried out an urgent, focussed inspection on Knole ward and Littleoaks ward. Concerns had been raised with us, including the leadership of the service, number and severity of incidents affecting the health, safety and welfare of young people on the wards and the safety of the ward environment. We looked at Knole ward, a 15 en-suite bedrooms admission ward, and Littleoaks ward, which comprises seven en-suite bedrooms, both for males and females aged between 12-18 years of age. At the time of the inspection there were 12 young people on Knole ward and 6 young people on Littleoaks ward.

Cygnet Hospital Godden Green is registered for the following regulated activities: assessment or medical treatment, for persons detained under the Mental Health Act 1983; treatment of disease, disorder or injury.

The service had a registered manager at the time of the inspection. However, following the inspection we were informed the registered person no longer worked for the service. The provider informed the Care Quality Commission they had identified a new person to take over as registered manager and the necessary paperwork will be completed.

From November 2017 to October 2018, the service was under enhanced surveillance by relevant stakeholders to ensure that the quality and safety of the service made sufficient improvements.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We found the following issues that the service provider needs to improve:

- The service did not provide safe care or treatment. The ward environments were not safe, clean or well maintained. The environment was not appropriately assessed to mitigate the risk of ligatures or items to enable young people to self-harm.
- Staff did not assess or manage risk well. Risk assessments and risk management plans were not always reflective of current risks or updated following incidents.
- The provider did not act to prevent the reoccurrence of patient safety incidents. We found repeated types of incidents that could have been avoided.
- Staff did not minimise the use of restrictive practices such as blanket restrictions. Staff over relied on increased observations.
- Staffing numbers and skill mix were not sufficient were not appropriate to ensure young people's access to therapeutic time or planned leave.
- The service was unclear about what incidents needed to be reported to external agencies.

Are services effective?

We found the following issues that the service provider needs to improve:

- Care plans were not always person-centred. Staff did not always ensure young people's care plans were updated or a true reflection of their needs.
- Staff were not always skilled and competent to provide care or treatment to young people.
- We observed a lack of therapeutic activity and engagement between staff and young people. Young people told us this led to increased boredom and distress.
- Staff were not sufficiently skilled in de-escalation techniques or effective in managing incidents and future risks.
- Information about incidents shared with external agencies was not always accurate or a true reflection of the incident.

Are services well-led?

We found the following issues that the service provider needs to improve:

Summary of findings

- Some senior managers and ward managers did not have the skills and knowledge to perform their roles. They did not have a good understanding of the services they managed and were not approachable for young people and staff.
- Staff did not know and understand the provider's vision and values and how they were applied in the work of their team.
- Staff did not feel respected, supported or valued. They reported not being able to raise concerns without fear of retribution. Staff morale was low.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were managed poorly. Leaders of the service were not sighted of the risks we found during the inspection.

Summary of findings

Information about the service

Cygnet Hospital Godden Green has an integrated Tier 4 (inpatient wards) child and adolescent mental health service alongside a Department for Education, Ofsted - registered school, the Knole development centre. Its specialist pathway offers an open acute admissions service (Knole ward), and a pre-discharge ward (Littleoaks ward) to allow for a smooth transition for young people returning home to their families.

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From November 2017 to October 2018, the service was under enhanced surveillance by relevant stakeholders to ensure that the quality and safety of the service made sufficient improvements.

Our inspection team

The team that inspected the service comprised three CQC inspectors and one nurse specialist advisor with expertise in child and adolescent mental health.

Why we carried out this inspection

We undertook an urgent, unannounced focussed inspection on Knole ward and Littleoaks ward. Concerns had been raised with us, including the number and severity of incidents affecting the health, safety and welfare of young people on the wards and the safety of the ward environment.

Summary of findings

As this was not a comprehensive inspection, we did not look at all of our key questions. We focussed on inspecting the specific areas of concerns raised with us.

We did not make any changes to the overall rating for the hospital or any of the five key question rating.

How we carried out this inspection

During this inspection we considered areas of the service to make a judgement on the following questions:

- Is it safe?
- Is it effective?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations and professionals for information.

During the inspection visit, the inspection team:

- visited Knole ward and Littleoaks ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with four young people who were using the service;
- spoke with the operations director, registered manager, ward mangers, team leaders, locum doctor and health care support workers
- reviewed incident forms and CCTV footage;
- looked at 10 care and treatment records of young people;
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider's services say

We spoke with four young people. Young people we spoke with told us they did not always feel safe on the ward. They told us there was a lot of staff on the wards but staff rarely engaged with them or motivated them. Young people also told us not all staff were aware of their needs and they were not responsive, particularly during times of distress. Young people described to us several incidents that had occurred on the ward and felt staff did not respond in a timely way or ensure the safety of everyone on the ward. Young people felt when they were involved in incidents, action taken by staff was at times restrictive and did not best support their needs.

Areas for improvement

Action the provider MUST take to improve
As identified in the warning notices served:

- The provider must ensure young people's risk assessments and risk management plans are updated and reviewed following incidents and appropriate action is taken to mitigate future risk and occurrence. (Regulation 12)
- The provider must ensure environmental risk assessments are kept up to date and identify all risks with clear actions set how these will be removed, remedied or mitigated. (Regulation 12)
- The provider must ensure all contemporaneous notes and records are an accurate and a true account of what is being reported and correlate across all records. (Regulation 12)
- The provider must ensure young people have good access to therapeutic activity both on and off the wards. (Regulation 12)
- The provider must ensure staff are not using restrictive practice to manage young people following incidents. (Regulation 12)

Summary of findings

- The provider must ensure interventions used to support young people or manage their behaviour are appropriate for that young person's needs. (Regulation 12)
- The provider must ensure all staff are competent and skilled to deliver safe care and treatment, especially, but not limited to, the use of observations, restraint technique and de-escalation skills. (Regulation 12)
- The provider must operate effective audit and governance systems and processes to make sure they continually assess, monitor and improve the service and delivery of safe care and treatment at all times. The provider must ensure they look at the quality of what their data. (Regulation 17)
- The provider must ensure they analyse themes and trends of incidents and take appropriate action and make improvements. (Regulation 17)
- The provider must ensure they review the quality of their staffs' supervisions. (Regulation 17)
- **Action the provider MUST take to improve as per the requirement notice:**
- The provider must ensure all notifiable incidents are reported to all relevant bodies.

Cygnet Health Care Limited

Cygnet Hospital Godden Green

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Cygnet Hospital Godden Green	Cygnet Hospital Godden Green

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The environment was not clean in all areas. We found trodden food in the main corridors and lots of dirty marks on walls and furniture throughout the wards. The service was not well designed to facilitate the delivery of safe care to young people. For example, there were poor lines of sight on both Knole ward and Littleoaks ward and there were unmitigated ligature risks. On Littleoaks ward the air conditioning unit had not been covered and there were other ligature risks present from this such as smoke detectors. The ceilings were easily accessed by young people climbing on window ledges and work tops, meaning it would not be difficult for young people to attempt to ligature from these anchor points.
- Both Littleoaks ward and Knole ward were mixed sex wards. The ward complied with national guidance on same sex accommodation as there were segregated washing facilities and females had access to a female only lounge. However, we noted that male patients used the female lounge on Knole ward and staff and young people reported that staff used the toilet in the female lounge on Littleoaks ward.
- The provider did not undertake thorough environmental risk assessments to assess the risks contained within the service. Staff completed checklists daily on environmental risks in the communal and bedroom areas of the wards. However, we saw that on the day of our inspection the staff member responsible had not completed the check of ligature points in the bedroom areas. These daily checks did not include identification of potential ligature points in communal areas.
- The providers environmental check of the wards, carried out three times a day by clinical staff, did not identify risks the inspection team observed such as removing smoke alarms, exposed screws, exposed door frames with rough edges and missing flooring. The provider was aware that there were ongoing and repeated incidents relating to the environment such as swallowing batteries and screws. Adjustments had not been made as the providers system had failed to identify all risks in the environment.

Safe staffing

- Staff and young people we spoke with consistently reported there were not always sufficient numbers of staff on duty to safely manage the wards. Four young people reported that there were rarely enough staff on duty which meant they missed out on attending the gym, local walks and shopping trips. Four staff members also confirmed this to be the case. Staff told us the wards sometimes felt unsafe and that they spent most of their shifts completing observations continuously.
- A staffing matrix was in place which stated the minimum number of qualified and unqualified staff needed on the wards'. However, we were concerned that this calculation did not meet the needs of the young people. Staff told us they did not always have time for a break which meant that they did not comply with the hospital policy on observations.
- Staff were tasked with constant observations, not enabled to have a break from carrying out continuous observations and did not have time to carry out meaningful interaction with young people.
- The wards had an allocated nurse in charge for each shift and tasks were allocated to ensure there were enough staff on duty to complete. Staff had a scheduled break during each shift. We reviewed the shift planning document for the day of our inspection and observed that staff were allocated to do enhanced and intermittent observations. However, we saw that for most staff they were required to complete observations for their whole shift, other than during their allotted break time. This meant there was very little staff time built in to support therapeutic interventions.
- There was not enough staff to ensure that young people could access 1-1 time with their allocated staff member. For example, we saw that one young person was allocated to a staff member who was completing

observations for all of their shift except for their break time. As the young person, was not on enhanced observations, it was not clear how the 1-1 protected time would be achieved.

- One young person told us they had not been able to take leave over Christmas due to insufficient numbers of staff; staff confirmed this as the case.
- Most staff we spoke with told us that staffing numbers were insufficient and that they regularly missed breaks and stayed late to ensure the safety of young people. One member of staff had worked in excess of 20 hours in one period when providing 1-1 care to a young person at the local acute hospital as the provider did not organise timely cover.
- Medical cover, whilst sufficiently resourced, was predominantly provided by locum doctors. The service had struggled to recruit and retain substantive doctors. This is an issue nationally and not just at this service. At the time of inspection, there were two employed consultants in post, however, one was on maternity leave and so locum cover was provided. There was a permanent medical director. However, they resigned shortly after the inspection with a replacement due to start in April 2019. There was one employed and one locum consultant who worked across the two wards as needed. The consultants were supported by locum associate specialist doctors. Outside of usual working hours, the service operated a duty doctor system. Several staff we spoke with told us that due to the temporary nature of the medical cover, it was difficult for them to get consistent medical advice and support from the doctors.

Assessing and managing risk to patients and staff

- The provider had an engagement and observation policy issued in July 2018. The policy stated that staff completing observations on young people were to have received a formal briefing on the policy. However, six staff we spoke with were not familiar with this policy and had not received any policy guidance when joining the organisation.
- The quality of individual risk assessments for young people were poor. Staff did not update or review risk assessments following incidents. The risk of similar incidents being repeated was not mitigated or managed. We saw several examples where similar, preventable incidents reoccurred.
- We reviewed 10 young people's care records during the inspection. From these, we found risk management plans were not always updated to reflect when a young person's risk had increased following an incident and how risks could be managed appropriately to respond to young people's changing needs. For example, we saw repeated types of incidents on the wards including two incidents, involving three young people, who had swallowed liquid solution from an ice pack when left unsupervised. We found repeated incidents of young people going absent without leave from the ward and main entrance of the lobby, which resulted in the need for police assistance. The provider did not do all that was reasonably practicable to mitigate such risks. Control measures were not put in place to ensure the risk remained as low as reasonably possible, or address the need for a change in practice.
- Where staff carried out enhanced observations with young people they did not always have the observation charts and we found these were completed retrospectively and were not always accurate. Three staff we spoke with confirmed that observation charts were regularly completed retrospectively. One young person told us that they were not checked every 15 minutes as they were supposed to be according to their agreed level of observations.
- Staff relied heavily on observations to manage increasing risks presented by the young people. We observed a lack of therapeutic activity across the wards. Young people we spoke with told us there was a lack of meaningful engagement from staff, lack of available activities and time off the ward environment, which lead to increased levels of boredom and frustration. We observed staff using restrictive practice to manage young people following incidents. For example, staff removed board games following young people swallowing foreign objects. The television was also removed for use by all, following an incident with one young person. This meant that young people overall could not enjoy the board games or the communal television. There was a clear over reliance on the use of enhanced observations in managing young people's

behaviour. Staff we spoke with could not describe any other interventions they would use. In addition, we observed higher than expected levels of observations across the wards. Three young people we spoke with reported that boredom led to increased frustration and distress which in turn affected their behaviour.

- Individual risks were not always addressed. One young person with was supposed to have specific interventions relating to their physical wellbeing. This young person told us staff had not carried out these interventions for over a week and staff had not noticed or taken action in response to increased risks. Therefore, staff could not be assured that this young person was receiving safe and appropriate care for their needs. Similarly, we found young people with a history of seizures which were not detailed in their care plans.
- During the inspection, we observed two incidents and a further three on CCTV footage. We observed that staff did not demonstrate skill in de-escalation and these incidents were poorly managed. During one incident, we observed staff appearing to push the young person out of the way, during another we observed staff ignoring the young person and overall, we observed staff reacting to young people's increasing distress rather than proactively trying to engage with them. We immediately escalated this to the senior leadership team who took the appropriate urgent action.
- Staff were not always aware of the individual risks of the young people. We found lots of examples where staff could not describe the risks such as handover lead staff not knowing why young people were on enhanced observations, 1-1 staff not knowing what the risks were for the young person they were observing and four staff said they only got risk information from handovers and never looked at risk assessments or care plans.

Safeguarding

- Staff knew how to identify and raise safeguarding concerns. However, information sent to the local authority safeguarding team was not always reflective or accurate when reporting an incident. For example, we found one example where the severity of a serious safeguarding incident had been minimised in the notification and reporting to the external bodies. Similarly, we found numerous notifications that were not reported without delay.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew how to report incidents as they arose. However, most staff we spoke with said that not all incidents were reported. They gave reasons such as lack of time and the fact that there were so many incidents to report. We observed a culture of acceptance that incidents were somewhat unpreventable. We reviewed 10 sets of care records and found over 10 incidents that whilst reported in the progress notes had not been reported as an incident.
- The provider did not ensure that lessons were learnt when incidents occurred. The standard response to incidents was to increase the young person's level of observations or put in blanket restrictions. We saw little attempt to understand the root causes of the behaviour or to put in other measures of support. Incidents were frequently repeated without sufficient mitigation in place to prevent reoccurrence. For example, we observed many incidents of young people going missing who did not have leave from the service, swallowing objects such as batteries and screws and attempts to deliberate self-harm. The majority of staff we spoke with could not describe any learning arising following incidents other than increasing the young person's level of observation.
- The service was unclear about what incidents needed to be reported to external agencies. For example, the service would complete statutory notifications to the Care Quality Commission that were not notifiable and not always report incidents that were. Similarly, commissioners reported that they had concerns that service were over reliant on commissioners to guide them as to which incidents were reportable and to who.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Staff did not ensure that changes to a young person's presentation or needs were captured in their care plan. Of the 10 care records we reviewed all had a care plan in place but four of these did not include the up to date needs of the individual. Care plans were not reviewed regularly enough to support the needs of young people. We observed care plans were completed at the point of admission or shortly after but the provider could not evidence that these had been reviewed.
- Of the 10 care plans we reviewed, one young person had physical health needs that were not identified in the care plan, one did not identify the risk of the person going AWOL and overall, they lacked detail and meaningful actions. Staff recorded actions which were not specific to the young person such as offering time to talk and encouraging them to use coping strategies but we saw little evidence of person centred care planning.
- Staff told us they did not have time to look at care plans. Some care plans we reviewed did highlight therapeutic activity and engagement but staff were not aware of these interventions as had not read the information. Two young people told us they had not been involved in formulating their care plan but had been asked to sign the care plan as a marker that they agreed with it.

Best practice in treatment and care

- We observed a lack of therapeutic activity and engagement between staff and young people. In our discussions with staff, staff demonstrated an over reliance on increased observation levels to manage young people's behaviour. Staff could not describe any other interventions they would use to support young people and reduce incidents. Young people told us whilst on observations staff did not engage in a meaningful way that interested them.

Skilled staff to deliver care

- Staff we spoke with demonstrated a lack of understanding of the needs of the young people in the service. Four staff we spoke with said they had not received a robust induction at the start of their employment at the service. These staff had not been given time to look at relevant policies or familiarise themselves with care plans and two of the four staff reported that had received no induction at all.
- Staff were not receiving regular supervision. Ward leaders told us that staff received supervision every four weeks. However, three staff we spoke us told us they had not received supervision with their manager for over six months. A further two staff told us they had supervision every few months but that the quality did not support their development. One staff member said they had not had any discussions about their career development through supervision and another said supervision was a tick box exercise. We reviewed three sets of supervision records and found that there was little focus on the individual staff member and the records were not very personalised.
- The service did host bi-monthly development days. However, staff said these were mostly presentations done by the doctors working at the service and that they did not always feel relevant or beneficial.

Multi-disciplinary and inter-agency team work

- Communication between the provider and external agencies was not always appropriate. Incidents which required a safeguarding referral were not always a true and accurate reflection of the incident. Information was either missing or incomplete.
- There were shift to shift handovers and daily multidisciplinary team meetings where incidents and safeguarding concerns were discussed. However, action was not always taken to safeguard young people and prevent future reoccurrence of the same incident happening.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- Leadership of the service was inconsistent. There was an interim ward manager on Littleoaks ward and a newly appointed ward manager on Knole ward. There had been constant changes to the leadership of the service and clinical team. The provider reported challenges with recruiting and retaining sufficiently skilled and experienced ward managers and senior clinical staff.
- Some senior managers and ward managers did not have the skills and knowledge to perform their roles. Some did not have a good understanding of the services they managed and were not approachable for young people and staff. For example, some of the managers were not aware of the risks we identified during the inspection. Similarly, some managers could not describe or demonstrate what a good service would like and how they would help implement these changes.
- Staff described a culture that did not value staff or encourage staff to speak up when things were not going well. Several staff spoke of managers having expectations that staff would not take regular breaks and work late as needed. Two members of staff reported having been spoken to in a detrimental way by one of the service managers in front of their peer group. There had been no permanent manager on Littleoaks ward for several months prior to our inspection. Staff said this had impacted on the quality of care as there was nobody ensuring that staffing levels were sufficient and they were not having regular team meetings.
- We were concerned about the high numbers of whistleblowers and staff that raised concerns to the Care Quality Commission in the months prior to the inspection. For example, we received several separate concerns about supervision, high use of observations, poor culture and high levels of incidents. Staff that reported concerns said they did not raise concerns internally as nothing was ever done in response and that managers were not receptive to their concerns. We discussed this with the provider during and after the inspection, who confirmed some of the concerns had not been raised directly with them and acknowledged there was a concern with culture and attitude at the service.
- Senior staff we spoke with did not demonstrate the appropriate level of skill or knowledge to effectively lead a high functioning team. Senior staff at the service were not taking enough action to address the restrictive nature of care being delivered or to improve the quality of care given. The managers we spoke with also demonstrated a reactive approach, responding to incidents as they arose but not taking action to ensure that learning took place to reduce the likelihood of reoccurrence.
- Following our inspection, the registered managed resigned from post. The provider brought in leadership from other Cygnet led services to focus on improving the quality and safety of the service.

Vision and strategy

- The organisation had a set of corporate values; integrity, trust, empower, respect and care. Staff we spoke with were not familiar with these values and could not describe how they related to their everyday work. Additionally, we did not see these values evidenced in staff practices both in relation to direct care of young people or in the interactions between staff, especially from managers.

Good governance

- We were concerned that the nature and severity of the concerns raised to us prior to the inspection were similar in nature to the concerns that prompted the inspection in November 2017. The service was under enhanced surveillance until October 2018. This demonstrated that the provider did not have the appropriate systems and processes in place to ensure the safety and quality of the service without enhanced scrutiny and support from the multiple agencies involved.
- We found the provider did not operate effective audit and governance systems and processes to make sure they assessed and monitored the service always. This was not undertaken in response to the changing needs of young people on the wards. For example, there was no robust system in place to reduce the risks associated to the health safety and/or welfare of young people on Knole and Littleoak wards. This included repeated incidents on the wards that were not identified, monitored or learned from.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Ward and service level managers did not demonstrate sufficient oversight of the risks we identified during the inspection. For example, the service did not monitor incidents occurring against incidents reported to be assured of a positive reporting culture. Similarly, restraint incidents were not being routinely reviewed by managers to ensure staff were responding a person-centred, least restrictive way.
- Managers did not ensure that all staff were receiving regular and meaningful supervision. The service did not hold regular team meetings.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents 18 (1) (2) (a) (b) (e) (f)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2) (a) (b) (c) (d)**

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 **Regulation 17 (1) (2) (a) (b) (c) (f)**