Mildmay Oaks

Quality Report

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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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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.

Summary of findings

Overall summary

We rated Mildmay Oaks as requires improvement because:

- The hospital did not have a full multidisciplinary team (MDT) in place and could not offer the treatment required by patients. The hospital had a high staff vacancy rate, and the locum staff employed to fill the gap were not trained specifically to work with people with a learning disability.
- Care plans focused on managing challenging behaviour and the legal aspects of patients' care, rather than their recovery. Care plans were not provided in an accessible format for patients.
- There were delays in requesting second opinion appointed doctors to review and agree appropriate treatment for patients detained under the Mental Health Act.
- Staff did not always carry out a mental capacity assessment at the appropriate time. When staff had completed capacity assessments, they were not decision specific.
- Staff had not transferred all information held on electronic records onto appropriate paper records.

However:

- The management team had identified most of the areas of concern identified during the inspection. They had only been in place for eight weeks and already had developed an action plan to address the lack of a full multidisciplinary team and had linked in with the Priory Group's main recruitment programme.
- The management team was in the process of reviewing all governance procedures in the hospital. The governance system in place did not meet the standards set by the Priory Group and did not provide the management team with the assurance they needed about the quality of care provided.
- A forum had been set up to address restrictive practices, within the hospital, and patients had been included in this group.
- All wards had comprehensive health and safety audits in place that identified action to address any issues. A daily hospital handover meeting reviewed all safety issues, patient and environmental risks and agreed action to address any issue.

Summary of findings

Contents

Requires improvement

Mildmay Oaks

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Mildmay Oaks

Mildmay Oaks Independent Hospital is a low secure and locked rehabilitation service for men and women with learning/intellectual disability and autism spectrum disorder.

There are four wards at Mildmay Oaks:

- Bramshill – Five bed male locked rehabilitation
- Eversley – Eight bed male locked rehabilitation
- Heckfield – Eight bed female locked rehabilitation
- Winchfield – 18 bed male low secure

Mildmay Oaks is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury

At the time of the inspection, the service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is ran.

At the time of this inspection, Partnerships in Care was merging with The Priory Group. The service was in transition between providers which is why there is reference to both

Partnerships in Care and The Priory Group throughout this report.

Our inspection team

Team Leader: Gavin Tulk, Inspector.

The team that inspected the service comprised of two inspectors, a clinical psychologist and two mental health act reviewers.

Why we carried out this inspection

We undertook a short notice focused inspection to find out whether Partnerships in Care Limited had made improvements to Mildmay Oaks since our last comprehensive inspection of the service in March 2016.

We last inspected the service in March 2016 and rated it good overall. We rated the service as good in the safe, responsive, caring and well-led domains. We rated the effective domain as requires improvement.

Following the March 2016 inspection, we told the provider it must make the following actions to improve Mildmay Oaks:

• The provider must ensure staff receive appropriate mandatory training.

We issued one requirement notice which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 18 (2) (a) Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. Staffing.

We received an action plan from the provider and reviewed their progress against this plan at a meeting with them.

During this inspection we concluded that the provider had taken sufficient action to meet the requirements set out in our requirement notice relating to Regulation 18.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection, we reviewed information that we held about wards for people with a learning disability and / or autism. This information suggested that findings from the inspection in March 2016 were still valid. Therefore, during this inspection, we focused on those issues that were remaining from the March 2016 inspection, and inspected the effective and well-led domains. We also found evidence on site in relation to the safe and responsive domains, which we have reported on, but we did not look at all the aspects of those key questions.

During the inspection visit, the inspection team:

- visited three of the four wards at the two hospital sites
- spoke with eight patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with ten other staff members; including doctors, nurses and social workers

We also:

- looked at eight treatment records of patients
- looked at 35 records in relation to capacity and consent
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Patient feedback varied. Patients told us that overall staff were caring and happy to help. However, we were told that some staff spent too much time in the office and not on the ward.
- Patients told us they felt safe in the hospital, although some patients did get angry and this affected the atmosphere.
- Patients told us that they had not received the treatment they needed and no one was able to tell them when they would receive it.
- Patients told us that the activities offered were not interesting and they were often bored.

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?

Good

As this was a focused inspection looking at the effective and well-led questions, we did not look at all the aspects of the safe domain.

- Rotas showed that the hospital covered shifts with the identified number of staff.

However:

- There was a 75% vacancy rate for qualified nurses.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Care plans were not recovery focused and did not meet the identified needs of the patients.
- The hospital did not produce care plans in an accessible format for patients and no patients had care plans around communication.
- Behaviour care plans focused on managing challenging behaviour rather than preventing it from occurring.
- There was not a full multidisciplinary team in place, which meant the hospital could not offer the appropriate psychological therapies to meet the patients' needs.
- When staff created paper records they had not ensured all the necessary information from the electronic record was included.

However:

- The staff team assessed patients' physical health needs and care plans were developed to meet any identified need. A local GP visited regularly.

Are services caring?

Good

At the last inspection in March 2016, we rated caring as **good.**

Since that inspection, we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive?

Good

As this was a focussed inspection looking at the effective and well-led questions, we did not look at all the aspects of the responsive domain.

- Patients told us they were bored and unhappy with the activities on offer.

Summary of this inspection

Are services well-led?

Requires improvement 

We rated well-led as **requires improvement** because:

- The wards did not have goals based on the provider's values.
- The governance processes did not meet the Priory Group's standards.

However:

- The current management team had been in place for eight weeks and had conducted reviews to identify concerns and develop action plans to address them.
- The senior management team had set up a forum, including patients and staff, to review all restrictive practices.

Detailed findings from this inspection

Mental Health Act responsibilities

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

There were delays in requesting a second opinion appointed doctor. Not all of the necessary information was included in the application forms and the responsible clinician had prescribed medication that was not agreed on the T2 form. These forms allow medical professionals to prescribe medicine to people detained under the Mental Health Act and indicate the patient has capacity to understand the nature of the treatment.

Staff had not updated care plans to reflect changes in consent to medication.

The hospital had a Mental Health Act administrator in place. They scrutinised Mental Health Act records and could give advice to staff about the Code of Practice. They conducted audits and then reviewed the results to improve the service.

At the time of our inspection, 31 patients were detained under the MHA. Staff read patients their rights on admission and then monthly. Patients could access an independent mental health advocate (IMHA), who visited the hospital weekly.

All permanent staff were trained in the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

All substantive staff had completed training in the Mental Capacity Act. Nursing staff were able to explain the principles of the Mental Capacity Act. However, support workers did not fully understand their responsibility under the Mental Capacity Act.

Patients subject to Deprivation of Liberty Safeguards had mental capacity assessments in place. Consent documentation had been audited.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Good

At the last inspection in March 2016 we rated safe as **good.** We did not see anything during the inspection to change this rating. As this was a focussed inspection looking at the effective and well-led questions, we did not look at all the aspects of the safe domain.

At the time of the inspection, there was a large number of staff vacancies at the hospital. This included 75% of registered nurse posts and 100% of occupational therapist and speech and language posts. However, the speech and language post was a new post created after the hospital director identified the need for this role. Since our inspection, the hospital has filled the speech and language post. The vacant psychologist post had been recently filled by a locum. We were told that the nursing posts were filled by long term agency staff and we reviewed rotas and saw that the same agency staff were being used and that all registered nurse shifts were filled.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

We looked at seven care records and saw that staff had completed assessments for all patients. The assessments identified the patients care and treatment needs, prior to their admission to the service.

- The hospital was not able to provide the treatment identified in patients' pre-admission assessments. For example, the hospital could not provide the psychological input needed for patients to move to a lower level of security.
- Patients could remain in hospital longer than needed because care plans did not address all identified assessed treatment needs. Care plans did not focus on recovery. However, staff did reviewed care plans regularly.
- Staff had not completed communication care plans for any of the patients. There was no quickly accessible information for staff to help them identify early warning signs of distress or how to support patients through these feelings.
- We saw care plans for two patients who staff had moved temporarily to a quieter area of the ward. They did not address any individual needs the patient had at the time as the plans were identical with only the patients personal details different.

Requires improvement

Wards for people with learning disabilities or autism

- Patients underwent a physical health examination on admission and care plans identified any ongoing needs. However, we saw one patient's assessment identified they needed dental treatment but there was no evidence in their care records that this had taken place.
- Patients had positive behaviour support plans, but they did not contain information on how staff could prevent challenging behaviour. The plans focused on how staff could manage challenging behaviour.
- The hospital only employed four staff with specialised training in learning disabilities. This meant, for example, that staff had not developed care plans in a format suitable for patients with a learning disability. Patients did not have access to care plans in easy read format, and we saw no evidence of patient involvement in the development of care plans. The deputy hospital director told us that they were meeting with the Priory Group recruitment team and were looking to target learning disability nurses.
- Care records were stored on the electronic care records system. We identified that not all information on electronic records was transferred on to paper medication cards. For example, three patients had allergies recorded on the electronic system but this was not recorded on the medication cards. We advised the hospital staff of this at the time, who agreed to address the issue. We noted during the inspection that the system was very slow. It was explained that they were integrating their own system with that of the previous provider and were in the process of improving the records system's functionality. Staff told us that they were able to access important information when needed.

Best practice in treatment and care

- The Hospital did not provide the expected treatments for this type of service as identified by the Department of Health because they did not have appropriately skilled professionals; for example, occupational therapists or, until recently, psychologists. Treatments did not address life skills such as coping with stress and communication, as recommended by the National Institute for Health and Care Excellence (NICE). Patients told us they had not received any therapy or psychology input since admission. They told us they did not know what they had to do to be discharged as they had been told prior to admission that they needed to complete therapy programmes at the hospital to be discharged.
- The Hospital had started to use Health of the Nation Outcome Scales (HoNOS) developed by the Royal College of Psychiatrists to identify the effectiveness of treatments at the hospital.
- Patients had good access to physical healthcare, including a GP who visited the service weekly.
- The provider had a programme for clinical audits, which included infection control. Each ward had a health and safety audit and up to date ligature audits. The provider had identified areas for improvement and developed action plans to address them. For example, consent to treatment and Mental Health Act documentation.

Skilled staff to deliver care

- At the time of our inspection, the hospital was unable to offer psychological therapies recommended by NICE because they did not have a full multi-disciplinary team to provide input to the wards. The hospital had a consultant psychiatrist and a full time social worker. There was no permanent psychologist and there were vacancies for two psychology assistants. The hospital also had vacancies for three occupational therapists and a speech and language therapist. The deputy hospital director told us they were recruiting a senior occupational therapist, two occupational therapists and a speech and language therapist. After the inspection, the hospital director told us they had recruited into the occupational therapy posts and staff would start on a locum to permanent basis within two weeks. The service had only four substantive nurses out of a required staffing complement of 22. Agency nurses on locum contracts covered posts and rotas we reviewed showed that the hospital was using the same agency staff to help provide consistency. However, only two of the nurses at the service were specialist learning disability nurses. This meant that whilst nurses were skilled and experienced in a mental health ward environment they may have lacked specific skills in relation to the patient group. For example, we found that whilst care plans ensured patient safety they did not address patients' specific therapeutic needs and needs connected with their learning disability. Health care support workers understood how to provide

day-to-day support for patients and were able to deliver care in line with patients' care plans. Support workers understood how to support patients safely in the community, but there was no clinical leadership to enable them to work with patients in a therapeutic way. The hospital director was working with the Priory Group recruitment team to address the hospital's vacancies. They had set a target of filling a vacancy every week, were continuing to actively recruit longer term locum posts including occupational therapy, and had reviewed the terms and conditions of employment, increasing the starting rate of pay.

- Between January and April 2017, 87% of staff had received face-to-face supervision every month. The provider target was for 95% of staff to receive monthly face-to-face supervision. Records we reviewed showed that supervision covered appropriate subjects. At the time of the inspection, 80% of staff had received an annual appraisal.
- Locum staff had not received the specialist learning disability induction training provided by the hospital for working with people with learning disabilities. Whilst the ward environment was safe, only four nurses in the hospital were substantive with the other nurses on locum contracts. As none of the locum nurses were learning disability qualified they lacked the training necessary to work effectively within a recovery model with this patient group. This was evidenced by a lack of recovery care plans and positive behaviour support plans. Care planning focused on the Mental Health Act and risk management.
- At the time of the visit, no staff were under performance management. However, the deputy hospital director was aware of the policy. The deputy hospital manager was able to explain how they had used the disciplinary policy and how they had linked with other care providers regarding concerns about staff on bank/locum contracts.

Multi-disciplinary and inter-agency team work

- The service did not have regular and effective multi-disciplinary meetings due to a lack of employed specialist staff. We saw that some multi-disciplinary meetings regarding patient care consisted of the consultant psychiatrist, a ward nurse and the social worker. There was minimal psychological input to these meetings. Due to the missing MDT professions, the hospital was unable to develop effective person-centred care plans focused on individual patient recovery.
- There were good relationships with external agencies. The provider employed a full time social worker who liaised with organisations such as the local safeguarding adults team, the local police, commissioners and families.
- The deputy hospital director told us that all patients at the hospital had received a care and treatment review (CTR). This is a review of patients with a learning disability in hospital to identify if they need to remain in hospital and if they are receiving appropriate treatment. The deputy hospital director told us that the CTR's had identified that patients were not receiving the treatment they required due to the lack of a full multi-disciplinary team.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The hospital had a Mental Health Act administrator on site and an area manager who scrutinised paperwork and gave advice on the Mental Health Act (MHA). Staff we spoke with were aware of who could give advice on the MHA.
- The responsible clinician had clearly identified any restriction relating to leave on the appropriate leave documentation. Patients were aware of the terms of their leave.
- The provider had trained all staff in the MHA and at the time of our visit there was 100% compliance with this. Staff we spoke with had a good understanding of the MHA and the Code of Practice.
- We reviewed 31 records of patients detained under the MHA. Nineteen patients' treatment had been authorised by a T3 certificate (a certificate issued by a second opinion appointed doctor (SOAD) when a patient is either not consenting to the medication prescribed for them, or has been assessed as not having the capacity to consent). There were 11 patients whose treatment was authorised by a T2 certificate (a certificate issued by the patients' responsible clinician when they have

assessed the patient as having the capacity to consent to treatment, and they have done so). We did not find evidence that any of these 11 patients had had mental capacity assessments in relation to this.

- We saw that there had been delays in requesting SOAD's to review and agree treatment, for patients treated under section 62 (urgent treatment) and when the patient had been treated for three months and either lacked the capacity to consent to ongoing treatment or was not consenting. We also saw that requests for SOAD's did not have full details of the proposed treatment, which meant it took longer for the SOAD to review the patient's treatment. We saw that staff had given one patient medication which according to his medication chart was authorised by a T2 certificate, however when we looked at the T2 certificate this medication was not on there. At the time of the inspection, staff had not told the patient about this mistake. We also saw that a patient was being treated on a T3 certificate, despite his care plan stating he had capacity to consent to medication and was being treated on a T2 certificate. An audit of capacity to consent documentation had been completed. The audit identified a number of improvement actions. For example, nurses needed to ensure they checked that medications were authorised to be given when a patient lacked capacity to consent and for a second opinion appointed doctor to be proactively requested to avoid the need to treat patients under section 62 (Urgent Treatment) of the MHA.
- The provider kept MHA paperwork on the electronic patient record system. We reviewed patients' records and saw that staff explained their rights to patients on admission and then monthly. Patients' rights were available in an assessable format, such as pictures, if required. However, we also identified one patient was having their section 132 rights (explanation of what part of the Mental Health Act the patient is held under and their right to appeal) read to them when they were not detained under the Mental Health Act. At the time of the inspection, the staff had not explained this to the patient. We saw that audits of Mental Health Act documentation took place and identified action to take where required.
- There was an independent mental health advocate (IMHA) that visited the hospital once a week. There were photographs of them on the ward notice board and patients could request to speak to them.

Good practice in applying the Mental Capacity Act

- The provider had trained all staff in the Mental Capacity Act 2005 (MCA).
- Nursing staff were able to explain the principles and implementation of the MCA. However, the two health care support workers we interviewed did not fully understand their role under the MCA as they told us any capacity issues would be care planned by the qualified nurses.
- There was a policy in place in relation to the MCA and all staff could access this when needed.
- At the time of our visit, three patients were subject to Deprivation of Liberty Safeguards (DoLS). These safeguard the rights of patients who are not detained under the MHA, but who lack capacity to consent to treatment, while allowing them to receive the treatment they require. Mental capacity assessments for patients subject to DoLS, rather than being decision specific as they should be, covered more than one issue.
- There was advice available on site around compliance with the MCA, and staff we spoke with knew who to approach for advice.

Are wards for people with learning disabilities or autism caring?

Good

At the last inspection in March 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

(for example, to feedback?)

Requires improvement

Wards for people with learning disabilities or autism

Good

At the last inspection in March 2016 we rated responsive as **good.** As this was a focussed inspection looking at the effective and well-led questions, we did not look at all the aspects of the responsive domain.

The facilities promote recovery, comfort, dignity and confidentiality

- The patients told us that the activities available to them in the hospital lacked variety and that they were often bored. They told us that the activities were repetitive and not always appropriate for them as they focused mainly on arts and crafts. We reviewed the activity rota on the ward notice board and saw that there was little choice for the patients. Patients and staff told us that the patients could access games consoles, televisions and music on the ward.

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

Requires improvement

Vision and values

- At the time of the visit, the service did not have an agreed local vision or objectives for the hospital. The deputy hospital director was able to tell us about the values of the wider organisation and that they were in the process of developing local team objectives based on the provider's values.
- The deputy hospital director knew who the senior managers were in the organisation. At the time of our visit, the local Operations Manager was visiting and other senior managers had regular planned site visits to address quality issues.

Good governance

- At the time of the inspection, the hospital used the governance reporting systems from the previous owners. Governance information was reported to the Priory healthcare quality team, who analysed the information before submitting it to the Priory board. The hospital director had reviewed the local governance arrangements since taking up the post. At the time of our visit, they were introducing the Priory governance procedures to ensure a better understanding of the quality issues in the hospital.
- Staff received mandatory training on a regular basis in areas such as conflict resolution, basic life support, safeguarding adults, Mental Capacity Act and Mental Health Act. At the time of our visit, 95% of staff had completed all mandatory training courses.
- The service was in the process of transferring to the Priory appraisal process. At the time of the inspection the hospital was below the providers target of 95% of staff receiving monthly face-to-face supervision. The hospital director had was monitoring this to improve compliance with the provider's target.
- We reviewed four months of staff rotas and saw that the identified number of staff, of the agreed grades, covered the wards. We were told by the deputy hospital manager that they were intending to increase the number of qualified nursing staff working on the rehabilitation wards to two on each shift.
- In addition to the scheduled audits, the manager had conducted a strengths, weaknesses, opportunities and threats analysis (SWOT) and had identified a number of the issues addressed in this report and developed an action plan in relation to this. For example, this covered care plans and mental capacity assessments.
- Senior management team meeting notes demonstrated they reviewed patient records from the wards, and identified any potential incidents that staff had not reported and requested an incident report. All incident forms were reviewed at the daily senior team meeting and they agreed any actions that needed to be taken.
- The deputy hospital director and all other staff members we spoke to said they had the authority needed to complete their role. The senior management team had administration support, but at the time of the inspection the wards did not. Staff were able to add items to the hospital risk register. Meeting minutes demonstrated the senior management team discussed items staff wanted to add and added them to the risk register if appropriate.

Requires improvement

Wards for people with learning disabilities or autism

Leadership, morale and staff engagement

- The service conducted a monthly staff morale survey. The survey asked staff to rate their morale out of 10, with 10 being the highest and one being the lowest, the average rating was seven. Most staff expressed feeling that positive changes were being made, although staff had concerns about the current merger and how it would impact on them.
- Staff did not report any concerns in relation to bullying. Staff we spoke with knew how to raise a concern and told us that they felt able to do so.
- We were told that there was opportunity for leadership training run by the provider.
- Staff told us that they would always inform a patient when there had been an error. We saw letters where the provider had written to a patient informing them of a mistake and what action they were taking in response.
- Staff reported good working relationships between staff members. We saw minutes of meetings, which showed that all staff members were able to give opinions and raise concerns. For example, staff had raised concerns relating to incident reporting and had agreed an action plan to address it in the daily hospital management meeting. Staff had influenced the development of the service through meetings and forums. For example, the reviewing restrictive practice group. This was a group set up by the hospital director after they had identified that there were a number of blanket restrictive practices in place that were not based of patient risk.

Commitment to quality improvement and innovation

- At the time of the inspection, the provider was working towards the College Centre for Quality Improvement accreditation organised by the Royal College of Psychiatrists. They had recently had a peer review as part of this process and were awaiting the report of this visit.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care plans are recovery focused, and that they reflect the needs of patients and are available in an accessible format.
- The provider must ensure they employ enough appropriately qualified professionals to meet the needs of the patients.
- The provider must ensure they appropriately assess patients' mental capacity.
- The provider must request second opinion appointed doctors when required. They must ensure that all the necessary information is provided to the second opinion appointed doctor and follow their agreed recommendations.
- The provider must ensure they transfer all relevant information held on the electronic patient record to any paper record staff are using.

Action the provider SHOULD take to improve

Staff should clearly record patient progress in relation to physical health issues.

- The provider should ensure staff understand their role in providing patients care under the Mental Capacity Act.
- The provider should ensure they achieve their target for face-to-face staff supervision.
- The provider should provide training on working with people who have learning disabilities to locum staff.
- The provider should ensure they have a local vision and objectives for the hospital.
- The provider should ensure that there are enough appropriate activities for the patients.

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 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure there were enough appropriately qualified professionals to meet the needs of patients.** **This is a breach of regulation 18(1)**

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 **The provider did not ensure that care plans met the needs of the patient, were recovery focused and in an accessible format.** **This is a breach of regulation 9 (1)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not always assess consent to treatment appropriately.**

This section is primarily information for the provider

Requirement notices

The provider did not request second opinion appointed doctors at the appropriate time, provide them with the full treatment plan or follow their agreed recommendations.

This is a breach of regulation 11(1)(3)(4)

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 The provider did not ensure that staff transferred all relevant information held on the electronic patient to paper records they used. This is a breach of regulation 12 (1)(2)(b)