Gladstones Clinic Lexham House

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 summary

We do not currently rate independent standalone substance misuse services.

We found the following issues where the service provider needs to make further improvements:

- The provider had created a training matrix system. However, the system was ineffective. The system in place did not give a clear oversight of the current staff training compliance rates. The provider had not set a mandatory training compliance target, therefore could not be assured of when an acceptable level of compliance had been achieved.
- Several of the provider's policies and procedures did not align with everyday clinical practice. The provider had not ensured that a policy review system was in place to ensure that policies were regularly reviewed and updated following national guidance and changes in clinical practice.
- The provider had not ensured that there was a clear system in place for clients to raise the alarm for assistance at night and at weekends. Staff were unclear of the newly implemented pendant alarm system which increased the risk to clients and lone working staff members in case of an emergency.
- The provider had not ensured that for one person attending the service as an 'experienced service-user' a completed criminal background check (DBS) and proofs of identity were not

Summary of findings

available. An experienced service-user was an ex-client continuing their engagement with the service which could develop into a peer mentor role. However, the person had access to vulnerable clients undergoing treatment at the service and attended staff clinical supervision. The service could not be assured they were of good character. This put clients at risk of harm.

However, we found the service had made some improvements since our last inspection in November 2016. We found the following areas of improved practice:

- The provider had ensured that a service medical emergency risk assessment had been carried out. The risk assessment recommended actions staff should take in a medical emergency, outlining medicines and equipment to be used.
- The provider had ensured that all appropriate emergency medicines were available and that there were sufficient stocks in place should they be required. These medicines were checked regularly and the checks were well documented.
- Staff regularly checked physical health monitoring equipment. Staff recorded when this had been completed.
- The provider had ensured that the admission consent forms had been updated to reflect the changes in practice. References about restraint interventions being used in the event of an emergency had been removed.
- The clinic room was no longer used as an office and was a dedicated space to assess and examine clients.

At the May 2018 inspection, we found that, whilst the service had made improvements to areas of practice and met some of the requirement notices, further improvements were required and some systems in place were ineffective. As a result of non-compliance of regulation 18 of the Health and Social Care Act 2014 (staffing) and the potential risks to clients at the service, we issued the provider with a warning notice for the same regulation. The provider must address the warning notice actions by 20 June 2018.

Summary of findings

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Summary of this inspection

Background to Gladstones Clinic Lexham House

Gladstones Clinic Lexham House provides care and treatment for people undergoing an alcohol or drug detoxification programme. The service provides care and treatment to both men and women, and it can accommodate ten clients. At the time of the inspection, there were seven clients in the service. The service also offered an outpatient programme to clients as a step-down programme following treatment. Outpatient clients were able to stay in accommodation that was local to the service.

Gladstones Clinic Lexham House is registered to provide: accommodation for persons who require treatment for substance misuse and treatment of disease, disorder or injury.

A registered manager was in post at the service. However, the registered manager was not based on site. The service had planned for the new service manager, who was based on site, to become the new registered manager.

The service received most referrals from private clients from inside and outside of London. However, on occasions statutory agencies referred in to the service.

The service was last inspected on the 22 and 23 November 2016. The November 2016 inspection was unannounced and we comprehensively inspected all aspects of the service. We found that the service had made improvements from a May 2016 inspection, but several areas needed embedding into everyday practice. The provider was issued with four separate requirement notices for breaches of regulation. We also made several recommendations for the service to address.

Our inspection team

The inspection team consisted of two CQC inspectors, one CQC assistant inspector, a CQC bank pharmacist specialist, and a specialist advisor with experience of working in the field of substance misuse as a nurse.

Why we carried out this inspection

We carried out a focussed inspection of this service to check whether the provider had addressed the breaches of regulations from the previous inspections in November 2016 and whether the required improvements had been made. At the November 2016 inspection, we found that some aspects of the service had improved from the previous inspection in May 2016, but several areas of practice needed embedding into everyday practice.

Following the November 2016 inspection, the provider was issued with requirement notices for breaches of the following regulations: Regulation 17(1)(2)(a)(b), Regulation 18(2)(a), Regulation 10(1)(2)(a), Regulation 12(1)(e) of the HSCA (Regulated Activities) Regulations 2014.

We told the provider that they must improve on the following areas:

• The provider must ensure that they undertake regular cleaning of physical health monitoring equipment.• The provider must complete a risk assessment on the management of medical emergencies. The risk assessment should be used to inform the choice of emergency equipment and medicines.

• The provider must ensure that all emergency equipment and medicines are checked regularly and the checks are documented.

Summary of this inspection

• The provider must ensure that staff complete their mandatory training to ensure that staff are supported to carry out their roles safely and effectively.

• The provider must ensure that clients who are receiving treatment at the service understand what they are consenting to. The consent to treatment form, which clients sign, should be aligned to their current policies and procedures.

• The provider must ensure that the clinic room environment is suitable and that the client's dignity, comfort and privacy is maintained whilst they are having physical examinations.• The provider must ensure that they keep personal client information secure and confidential.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

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

At this focussed inspection, we did not look at all five key questions. We checked areas concerning the service being safe, effective, responsive and well-led.

Before the inspection visit, we reviewed the progress of the service action plan that demonstrated how the requirement notices and recommendations were being addressed. We reviewed the provider's two previous inspection reports from March and November 2016.

During the inspection visit, the inspection team:

- visited the location and looked at the quality of the physical environment
- spoke with three clients
- spoke with one of the registered managers, the service manager and compliance manager
- spoke with four other staff members employed by the service provider, including a doctor, a nurse, support workers and therapists
- looked at specific areas of six clients' care and treatment records
- looked at four clients' medicines records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

Clients were very positive about the service. Clients told us that they felt safe and that staff were supportive to their needs. Some clients told us that their families had been fully involved in their care and treatment decisions.

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?

We do not currently rate standalone substance misuse services.

This was a focussed inspection and we did not inspect all areas.

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

• The provider had not ensured that all staff were up-to-date with mandatory training. The system in place to monitor mandatory training compliance was ineffective and was not up-to-date at the time of the inspection. The provider had not set a mandatory training compliance target, and therefore, could not be assured when an acceptable level of compliance had been reached.

• The provider had not ensured that there was a clear system in place for clients to summon assistance if they required it, particularly at night and at weekends. Staff were unclear of the newly implemented pendant alarm system which increased the risk to clients and lone working staff members in case of an emergency.

• The provider had not ensured that for one person attending the service as an 'experienced service-user' a completed criminal background check (DBS) and proof of identity was held by the provider. An experienced service-user was an ex-client continuing their engagement with the service that could lead to their development as a peer mentor. The person had access to vulnerable clients at the service and attended staff clinical supervision. The service could not be assured they were of good character and that it was appropriate for the person to be involved in confidential meetings.

• Ligature cutters were not located in an accessible place in the building. The building covered four floors and the ligature cutters were stored in the basement. Some members of staff were unclear of where the cutters could be found. This increased the risk of delays in case of an emergency.

However, we found the following areas of improvement since the previous inspection:

• The provider had carried out a service medical emergency risk assessment that advised staff on actions to take in case of a medical emergency, outlining the medicines to be used and equipment to be operated.

• Staff regularly cleaned physical health monitoring equipment and kept clear records of this.

Summary of this inspection

• Staff recorded monthly checks of medical emergency equipment and emergency medicines.

• The provider had ensured that there was a clear process in place for staff to follow in case of a client becoming distressed and aggressive. The service had ensured that references made to restraint interventions had been removed from the provider's admission consent form.

• The service held sufficient quantities of emergency medicines called Naloxone and adrenaline to administer the maximum doses in the event of a medical emergency.

Are services effective?

We do not currently rate standalone substance misuse services.

This was a focussed inspection and we did not inspect all areas.

We found the following areas of improvement since the previous inspection:

- The provider had recently written and implemented best practice policies that covered the safe management of medicines, medical processes and good practice guidance for medicine prescribed when required.
- The service had ensured that information posters were visible around the service. Information included signposting to mutual aid that supported the nine protected characteristics in the Equality Act 2010.
- In the six client records we reviewed, we found all clients had exit plans in place. An exit plan is a document in place that records the action the service would take in the event that a client exits planned treatment.

However, we found the following issues that the service provider needs to improve:

- The provider's admission consent forms did not include information relating to the staffing of the service at night and at weekends. There was a possibility that members of staff, possibly of the opposite sex, would be lone working at night and on weekends and would need to monitor clients' wellbeing including accessing bedrooms. The provider could not be assured that clients were aware of this and fully consented. Following the inspection, the provider sent to us the newly updated consent form which now included these details.

Summary of this inspection

- The provider had not yet ensured that copies of clients' exit plans had been retained once the client had left. The provider was unable to refer to exit plans in the event this information was required. The service manager told us that this would be implemented following the inspection.

Are services responsive?

We do not currently rate standalone substance misuse services.

This was a focussed inspection and we did not inspect all areas.

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

- Personal client information was still on display in the clinic room. The whiteboard included individual names and client history. This did not protect client confidentiality.

Are services well-led?

We do not currently rate standalone substance misuse services.

This was a focussed inspection and we did not inspect all areas.

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

• The provider did not have a policy review cycle in place which meant that policies and procedures did not always reflect current clinical practice and updates in line with national guidance. We found some examples of policies that did not refer to up to date national guidelines and examples of policies in circulation that were no longer used.

Substance misuse/detoxification

Safe	
Effective	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The service had an up-to-date health and safety assessment that identified areas in need of maintenance within the premises. The health and safety lead monitored the progression of actions identified in the health and safety assessment through a weekly safety check of the environment. At the time of our inspection, the item deemed to be a high risk was the service's boiler. During our inspection, an external contractor was repairing the boiler.
- The service had a detailed and comprehensive fire risk assessment. The service's most recent fire risk assessment had been undertaken in May 2018. The action plan was monitored on a weekly basis and staff had addressed areas of high or medium risk that required immediate attention. Staff had developed a detailed action plan to implement and address areas of lower risk.
- Staff had completed a ligature risk assessment of the environment that included action plans to manage potential ligatures. The risk assessment included review of the windows, door hinges, basin taps and light fittings. Staff carried out individual risk assessments on each client to ensure risks of self-harm were identified and mitigated. Following the inspection, the provider told us that ligature cutter safes had been installed on the two top floors of the building.
- At our previous inspection in November 2016, we identified that the service did not have a system in place for clients to summon assistance within the building. At the May 2018 inspection, we found that this was still the case. The service manager told us that they had purchased a pendant alarm for clients who were at risk. The staff member available would be contacted via a wrist watch. However, staff were unaware of this system. The risk was partly mitigated by staff carrying out regular eyesight observations of clients every hour or every 15 minutes for the first 72 hours for new admissions. However, there was still a risk of clients not being able to easily summon assistance out-of-hours and at the weekends when support workers lone worked.
- At our previous inspection in November 2016, we identified that, whilst the provider had equipment to treat medical emergencies, there was no risk assessment or guidance for staff that informed them which equipment or medicine to use in the event of an emergency. During the May 2018 inspection, we found that this had been addressed. The service had completed a risk assessment that advised staff on actions to take in the event of a medical emergency. This outlined medicines to be used and equipment to be operated.
- At the November 2016 inspection, we identified that physical health equipment was not regularly cleaned and there was no record that cleaning took place. During the May 2018 inspection, we found that this was no longer the case. The service had a cleaning schedule for rooms and for the cleaning of physical health monitoring equipment to mitigate the risk of infection. The service kept clear records of all items and areas that had been cleaned.
- During the November 2016 inspection, we found that emergency medicines and equipment were not regularly checked and there was no record the checks had taken place. At the May 2018 inspection, we found this had improved. Records showed that medical emergency equipment and emergency medicines were checked monthly. Whilst staff routinely monitored

medicine fridge temperatures, there was no record to show that room temperatures were monitored. The provider could not be assured that medicines were stored within the correct temperature range.

- At the November 2016 inspection, we found that the service was not following national guidance when disposing of clinical waste. The service had not ensured that waste collection met department of health guidance. During the May 2018 inspection, we found that this was no longer the case. Staff ensured that clinical waste was appropriately managed.

Safe staffing

- At the November 2016 inspection, we found that the provider had not obtained enhanced criminal background checks (DBS) for one person. Providers are required to complete an enhanced check for all staff who have access to vulnerable people. During the May 2018 inspection, we found some improvements. Whilst the provider had ensured that seven out of eight staff had an enhanced DBS in place, one person called an 'experienced service-user' did not have a completed DBS check in place and no proof of identity available. An 'experienced service-user' was an ex client who continued to engage with the service and had access to therapy groups. The 'experienced service-user' role was designed to allow ex-clients to continue their recovery journey and develop into a peer mentor worker. There was confusion at the service whether this role was classed as a staff member who would require recruitment checks. However, the experienced service-user took part in staff group supervision. This meant the person had access to confidential information relating to clients and had access to vulnerable clients at the service. The service could not be assured they were of good character. This put clients at risk of harm.
- At our previous inspection in November 2016, we identified that staff mandatory training completion rates were low with compliance rates below 75% in a number of areas. The provider had started using third party companies to provide an improved mandatory training programme. At the time of the May 2018 inspection, training records showed that not all members of staff had completed mandatory training and the systems in place to monitor training were ineffective. During our inspection, we were not able to access up-to-date mandatory training figures. The training matrix used to monitor mandatory training was incomplete. Following the inspection, the providers gave us an updated spreadsheet, which showed there were still gaps. Courses not completed included the care certificate and substance misuse awareness level one training. One support worker had not been assessed as competent to administer medicine but had administered medicine to a client in April 2018 on two occasions. The provider could not be assured that staff were adequately trained and equipped to carry out their role safely and meet the needs of the clients. This could put clients at risk of coming to avoidable harm.

Assessing and managing risk to clients and staff

- At the last inspection in November 2016, we recommended that the provider should ensure it had enough ligature cutters in the service to respond to an emergency. At our inspection in May 2018, we found that this had not been completely addressed. Additional ligature cutters had been purchased and were stored in the clinic room, however the clinic room was located in the basement of the building. Clients' bedrooms occupied the second and third floors which increased the risk of a potential delay in responding to an incident involving a ligature. Staff were unclear of the location of the cutters and one member of staff was not aware of what ligature cutters were. At the time of the inspection, we raised this concern to the service manager and quality compliance manager. The managers told us the ligature cutters were moved to the medicine keys which should be kept with a nurse at all times and then handed over to the night staff. The managers planned to order safety deposit boxes for each floor for the ligature cutters to be stored in.
- At the November 2016 inspection, we identified that the provider did not hold sufficient quantities of Naloxone and adrenaline to administer the maximum doses in the event of a medical emergency. At the time of the May 2018 inspection, we found that this had been addressed. Sufficient supplies of Naloxone and adrenaline were available.
- At the November 2016 inspection, we identified that the service's consent form stated that in the event of an emergency a client agreed to be restrained in order to prevent harm to themselves and others. The service did not have a restraint policy in place and staff had not

been trained in restraint techniques. During the May 2018 inspection, we found that this had been addressed. We reviewed six client records and found that the reference made to restraint had been removed from the consent form. The service manager confirmed that the process in case of an emergency is for staff to call the police. This was reflected in the provider's de-escalation policy.

Are substance misuse/detoxification services effective?
(for example, treatment is effective)

Assessment of needs and planning of care (including assessment of physical and mental health needs and existence of referral pathways)

- At the November 2016 inspection, we found that the service did not hold copies of clients' exit plans so that they could be referred to in case there was a problem. At the May 2018 inspection, we found in all six records reviewed that clients had exit plans in place, but the service had not yet ensured they retained copies for future reference. The service manager told us that staff would ensure these were kept following discharge.

Best practice in treatment and care

- At the November 2016 inspection, we identified that the provider did not have best practice medicines management protocols in place. This included a lack of protocols for the administration of 'as required' (PRN) medicine and the administration of medicine to relieve symptoms of alcohol withdrawal. During the May 2018 inspection, this had been addressed and new policies had been implemented by a new consultant psychiatrist in March 2017. The policies covered the safe management of medicines, medical processes and good practice guidance for medicine prescribed when required. In addition, the service was in the process of introducing a new policy on monitored withdrawals with staff being trained by the consultant psychiatrist in its delivery.

Good practice in applying the MCA(if people currently using the service have capacity, do staff know what to do if the situation changes?)

- The service had not ensured that client consent forms included the possibility that on weekends and out-of-hours, there may be occasions where one member of staff, possibly of the opposite sex, would need to enter bedrooms to carry out eyesight observation checks and monitor their wellbeing. Whilst staff ensured that on admission clients were verbally made aware of what they could expect from the service, this was not recorded. During the inspection, this was raised to the managers, who confirmed that this would be added to the agreement form for admission. The lack of formal consent from clients for this aspect of admission meant that clients would not be able to give fully informed consent and increased the risks of complaints being made about staff who are lone working.

Equality and human rights

- At the November 2016 inspection, we found that the service needed to improve the information that was available to clients that covered the nine protected characteristics contained in the Equality Act 2010. During the May 2018 inspection, we found that this had improved. Information posters were available around the service signposting clients to where further information could be found. The provider employed a diverse workforce.

Are substance misuse/detoxification services responsive to people's needs?
(for example, to feedback?)

The facilities promote recovery, comfort, dignity and confidentiality

- At our previous inspection in November 2016, we identified that the clinic room environment was also being used as an office and that clients' personal information was on display to other clients. At the time of the May 2018 inspection, this had partly improved. We found that staff had moved into a different office and the clinic room was no longer used as an office. However, personal client information was still recorded on the whiteboard including individual names and whether the client had completed a detoxification and

other physical health checks. This did not protect client confidentiality as clients could see the board. We raised this to the service manager and quality compliance manager to be addressed.

- Clients had access to a range of rooms to support their care and treatment. This included two lounges, a dining room, meditation room, therapy room and a kitchen. Clients were able to use the kitchen and lounges between therapy sessions.
- Clients had personalised bedrooms that contained a washbasin and furniture to store possessions. Four rooms were located on both the second and third floors with access to both male and female bathrooms.
- The service had a communal garden for all clients to use. The service had recognised that the garden needed some attention to ensure it was a welcoming place for clients during their stay.

Are substance misuse/detoxification services well-led?

Good governance

- At the November 2016 inspection, we identified that the provider needed to continue embedding new governance processes into the service. This included the provider setting a mandatory training compliance target and embedding the new training matrix. During the May 2018 inspection, we found that this had not been completely addressed. Whilst the provider was still strengthening the internal governance processes, aspects of the governance systems were ineffective. This had an impact on every day clinical practice. For example, the provider had not set a mandatory training compliance target. Therefore, the provider could not be assured of when an acceptable level of compliance had been achieved. The 'Gladstone's training policy' did not clearly state what training was required for each staff group and how often each course should be refreshed. The lack of guidance on training requirements meant that the provider could not be assured that staff were undertaking the correct training for their role.
- At the May 2018 inspection, the provider did not have a clear policy review cycle in place and policies were not always in place to support practice or updated when necessary. One of the registered managers confirmed this needed improving as policies were reviewed on an ad-hoc basis, when required. There was no guidance to indicate how often internal policies should be reviewed to ensure that they were in accordance with national guidance. We found outdated policies in circulation that no longer supported every day practice. The provider's medical emergency policy and procedure, dated November 2016, did not align with the provider's new medical emergency risk assessment.
- None of the provider's policies referred to clients informing the Driver and Vehicle Licencing Agency(DVLA) of their substance misuse treatment. The provider's policies did not refer to national guidance including the General Medical Council's (GMC) guidance on this topic. The GMC's guidance states a doctor should encourage clients to inform the DVLA of their substance misuse treatment if they hold a driving licence. The guidance states that doctors should consider reporting a client to the DVLA if they continue to drive and are medically unfit. We found in five out of six records reviewed that clients had not been encouraged to self-disclose their treatment if they held a driving licence and had access to a vehicle. The lack of policy increased the risk of clients not being appropriately assessed, potentially leading to clients driving unsafely.
- Whilst the provider was building a peer mentor group for ex-clients in recovery to support clients undergoing treatment, the provider had not ensured that there was a clear policy in place that clearly outlined the role for 'experienced service-users' who returned to the service following treatment to engage in therapy groups and the development role of peer mentor worker. A protocol was not in place that detailed the necessary recruitment checks needed for both of these roles including DBS checks. At the time of the inspection, there was confusion at the service to whether the 'experienced service-users' and peer mentors were classed as members of staff. One manager told us that these roles were not classed as staff. However, we found that peer mentor workers and experienced service-users were involved in the monthly staff clinical supervision where current clients were discussed. The lack of clarity had led to the provider not ensuring that one person who attended the service as an 'experienced service-user' had a completed DBS certificate prior to beginning their role and attending staff group supervision. Overall, the

lack of guidance in place for the roles increased the risk of people working beyond their competency and having access to information about vulnerable people without the appropriate recruitment checks being in place.

Leadership, morale and staff engagement

- The team were enthusiastic about the work they undertook and were complimentary about their colleagues. Staff we spoke we enjoyed working at the service and told us that their peers were supportive.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff members complete mandatory training when required, a mandatory training compliance target is set and a robust monitoring system put in place to monitor compliance rates.
- The provider must ensure that policies are implemented to reflect recommended and current clinical practice. Policies in place must be reviewed and updated in line with national guidance. This includes the provider putting in place a policy review cycle to ensure policies do not become outdated.
- The provider must ensure that there is a system in place for clients to summon assistance if they require it, particularly at night and at weekends.
- The provider must ensure that they comply with their DBS/Disclosure Policy and Procedure best practice guidance and obtain an enhanced check from the Disclosure and Barring Service for all staff prior to employment commencing.

Action the provider SHOULD take to improve

- The provider should ensure that ligature cutters are safely stored in suitable places for easy staff access and staff are fully aware of the location of ligature cutters in case of an emergency.
- The provider should ensure that personal client information is kept confidential at all times. This must include where information is written on whiteboards.
- The provider should include in the admission consent forms the staffing arrangements in place at night and at the weekends.
- The provider should ensure that the room temperature of where medicines are stored is monitored regularly and recorded.

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
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that there was a clear system in place for clients to summon assistance, particularly at night and at weekends when staff lone worked. This increased the risk of clients coming to harm in the event of an emergency. This was a breach of regulation 12 (1)(2)(b).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider had not ensured that a person attending the service as an 'experienced service-user', who had access to information about vulnerable people, was of good character. The provider did not retain a copy of the person's identity and had not carried out an enhanced criminal background (DBS) check. This was a breach of regulation 19 (2). This was a breach of regulation 19 (2).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

The provider did not operate effective governance systems to ensure that policies were regularly reviewed, updated and aligned with clinical practice and national guidance. This led to gaps in mandatory training compliance and national guidance not being adhered to.

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

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
Accommodation for persons who require treatment for substance misuse Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that there was an effective training monitoring system in place that was up to date and indicated when an acceptable level of compliance had been achieved. Not all members of staff had completed the appropriate training as is necessary to enable them to carry out the duties they are employed to perform. **This was a breach of regulation 18(1)(2)(a).**