Good

Black Country Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

Black Country Partnership NHS Foundation Trust
Delta House
Delta Point
B709PL
Tel:0845 146 1800
Website: www.bcpft.nhs.uk

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
TAJ11	Heath Lane Hospital	Gerry Simon Clinic	B71 2BG

This report describes our judgement of the quality of care provided within this core service by Black Country Partnership NHS Foundation Trust. 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 Black Country Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Black Country Partnership NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

We have rated forensic inpatient/secure ward as good overall because:

- Following our inspection in November 2015 we rated the service as 'good' for Effective, Caring, Responsive and Well led. Since that inspection, we have received no information that would cause us to re-inspect these key questions or change the ratings.

Summary of findings

However:

- Our rating of the safe key question remains requires improvement. This was because following our inspection of this service in November 2015, we asked the trust to ensure that training was provided to increase staff awareness of the Mental Health Act code of practice. During our inspection in October 2016, we found that less than 60% of qualified and unqualified staff had received this training. This was below the NHS national training standards and the trust's training compliance target.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were not up to date with mandatory training. This included training in safeguarding children and adults, and training in the Mental Health Act.

However

- We asked the trust in 2015 to review it's seclusion policy and ensured it adhered to the Mental Health Act code of practice. During our inspection in October 2016, we found that this had been completed and the seclusion policy had been updated and ratified in May 2016.
- We asked the trust to reduce the risks posed by ligatures points found during our 2015 inspection of the Gerry Simon Clinic. When we re-inspected the service in October 2016, we found that action had been taken to reduce ligature points within the service. Robust plans to further reduce ligature risks were monitored by the trust within local quality and safety forums. Detailed assessments were in place to mitigate ligature risks during the interim period.
- Risk assessments were completed using a range of standardised tools and we found they were patient centred and reviewed regularly.
- Equipment for use in emergencies and for physical health checks were available and maintained in line with manufacturers recommendations.
- Staffing levels were sufficient to ensure the service operated safely. Bank and agency staff could be used to supplement core staffing where required and to ensure that section 17 leave and patient activities took place.
- Staff received feedback from the investigations into incidents and met regularly to discuss lessons learned. All staff were aware of their responsibility to report incidents and were able to describe how to use the trust's electronic incident reporting system.

Are services effective?

Good

At the last inspection in November 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Summary of findings

Are services caring? At the last inspection in November 2015 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.	Good 
Are services responsive to people's needs? At the last inspection in November 2015 we rated responsive as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.	Good 
Are services well-led? At the last inspection in November 2015 we rated well-led as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.	Good 

Summary of findings

Information about the service

The Gerry Simon Clinic is a 15 bed forensic clinic for men with mental disorder, including intellectual disability and autistic spectrum disorders, who require specially adapted treatment programmes to complete their rehabilitation. The clinic is divided into three separate wards with five beds in each ward. There is a fourth area for activities. There is a large hall for ball games. In addition, there is a 'shared space' with the MacArthur Unit, which includes a conference room, family visiting room, office space, clinical room, as well as reception, gym, vending machine and art room facilities.

Patients are first admitted to the Willow ward. They then move to Sycamore ward, where they will engage in their therapies, and begin to learn the skills necessary for them to live safely in the community. On Cedar ward, patients continue to work towards discharge and take increasing responsibility for their own safety while accessing greater amounts of Section 17 leave.

There is a seclusion room and a de-escalation suite situated adjacent to Willow ward. The seclusion and de-escalation facilities are available for use by all three wards in the clinic. Bedrooms on Willow ward are not en-suite. Bedrooms on Sycamore ward and on Cedar ward are all en-suite.

Our inspection team

Team leader: Sonia Isaac, Inspector, Care Quality Commission.

The team that inspected the forensic inpatient/secure wards comprised a CQC inspector and two specialist nurse advisors.

Why we carried out this inspection

We undertook this inspection to find out whether Black Country Partnership NHS Foundation Trust had made improvements to their forensic inpatient/secure services since our last comprehensive inspection of the trust on 16-20 November 2015.

When we last inspected the trust in November 2015, we rated forensic inpatient/secure services as good overall. We rated the core service as requires improvement for safe, good for effective, good for caring, good for responsive and good for well-led.

Following this inspection, we told the trust that it should take the following actions to improve forensic inpatient/secure services:

• The Trust should provide Mental Health Act training for staff to update them in relevant changes to the Mental Health Act Code of Practice 2015.

• The Trust should review its Seclusion policy in line with the Mental Health Act Code of Practice 2015.

• The Trust should provide increased administrative support to the unit to assist with the timely filing of seclusion records in care records.

• The Trust should take action to reduce the risks posed by ligature points in the Gerry Simon Clinic.

We did not issue the trust with any requirement notices for the forensic inpatient/secure services.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following question of the provider:

- is it safe?

Before the inspection, we reviewed information that we held about the forensic inpatient/secure wards and

Summary of findings

requested information from the trust. This information suggested that the ratings of good for effective, caring, responsive and well led, that we made following our November 2015 inspection, were still valid. Therefore, during this inspection, we focused on those issues that had caused us to rate the service as requires improvement for safe. We also made a few recommendations at the last inspection which will be followed up at the next comprehensive inspection.

During the inspection visit, the inspection team:

- visited three wards at the Gerry Simon Clinic, looked at the quality of the environment, and observed how staff supported patients
- spoke with three patients who were using the service and one carer
- spoke with the manager and assistant manager of the Gerry Simon Clinic
- spoke with 4 other staff members; including nurses and an occupational therapist.

We also:

- reviewed eight risk assessments of patients using the service and 16 records relating to the use of seclusion facilities.
- 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

- People that we spoke with told us that the ward was always clean and tidy and that staff were available when needed. We were told by patients that staff treated them with dignity and respect and their physical health was assessed and monitored frequently.
- We were told by patients that they were able to access their care plans, that they were fairly written and took into account a range of needs. We were also given examples of families being invited to care planning approach meetings and plans being in place for section 17 leave and eventual discharge to a less restrictive environment.

Good practice

- All risk assessments had evidence of the completion of a person centred physical intervention plan. These were patient centred plans which followed guidance from the 2014 Department of Health policy: Positive and Proactive Care: reducing the need for restrictive interventions.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff attend mandatory training, including safeguarding for children and adults and use of the Mental Health Act.

Action the provider SHOULD take to improve

- The provider should ensure that when the use of seclusion is authorised, documentation is completed in line with trust policy guidance.
- The provider should continue to ensure that ligature risks are monitored and mitigated prior to the completion of the capital works plan for their removal.

Black Country Partnership NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Gerry Simon Clinic	Heath Lane Hospital

Requires improvement

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 layout of the unit was circular; this meant that corridors were curved and did not always provide clear lines of sight. Staff at the unit mitigated the risks of blind spots using curved mirrors and increased staffing.
- During our previous inspection in November 2015, we identified that their were a number of ligature points throughout the three ward areas and in the adjoining clinic areas. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Ligature risk audits had been completed for Sycamore, Willow and Cedar Wards in August 2016 prior to our re inspection of the service. Willow ward had been fitted with anti ligature door locks, door handles and collapsible shower rails but the other two wards had not. The trust had implemented a plan to remove or replace all ligature risk points by April 2017. Existing ligature risks had been documented and a plan of the unit had been produced with colour coded risks assigned. Staff were expected to have an awareness of ligature risks when coming onto shift and details about the existing risks were contained on a whiteboard in the staff handover room, in the nursing stations and covered in the staff induction to the unit, which was mandatory for all permanent, bank and agency staff. Further mitigation of ligature risks included increased observations of patient at risk or increased staffing levels.
- The Gerry Simon Clinic admitted male patients only and was fully compliant with Department of Health guidance on eliminating mixed sex accommodation.
- A clinic room was available and contained equipment for physical health monitoring, resuscitation equipment and emergency drugs. All equipment had been checked and maintained in line with manufacturers recommendations. Clean stickers were in place and evidenced dates of recent and future planned equipment checks. Fridge temperatures for the storage of medication were checked daily and logs of this were reviewed and found to be complete and up to date. Ligature cutters were available in the staff office and the clinic room emergency resuscitation equipment.
- The seclusion room was situated adjacent to Willow ward and a low stimulus area was also available for use during de-escalation. The seclusion room allowed clear observation and two way communication. Patients had access to toileting and shower facilities and a clock was visible from the seclusion suite on the wall outside. A foam removable mattress was also available for patient use if required. The seclusion room was fully compliant with the Mental Health Act Code of Practice.
- The wards were clean and tidy, free from odours and well maintained. Furniture was heavy but not fixed to the ground and patients reported it was comfortable to use. Staff completed monthly cleaning audits of each ward, the most recent being in October 2016. The average cleanliness score from the most recent audits across the three wards was 97%. Cleaning schedules were in place and were complete and up to date for bedroom and bathroom areas, the medication dispensary and communal areas including the lounge.
- The Heath Lane Hospital, where the Gerry Simon clinic was situated, had scored 99% for cleanliness in the 2016 patient led assessment of the care environment. Patient led assessments of the care environment are self-assessments undertaken the NHS and include at least 50% members of the public (known as patient assessors). They focus on different aspects of the environment in which care is provided, as well as supporting non-clinical services such as cleanliness.
- Staff adhered to infection control principles. Hand sanitiser was available for staff use at the air lock prior to entering the clinical environment and was also available in communal ward areas. A hand hygiene audit had been completed in October 2016 and the unit had achieved a score of 95% compliance. Annual infection prevention and control audits had been completed, the most recent in October of 2016. Areas covered included the disposal of waste, personal protective equipment, prevention of sharps injuries and the cleaning and decontamination of equipment used for physical health monitoring and resuscitation. Kitchen areas and linen and laundry rooms had also

Requires improvement

Are services safe?

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

had cleanliness audits completed. The average score of all infection control and prevention audits was 95% and areas had been identified for improvement where scores were below 100%.

- An annual environmental risk assessment had been completed in July 2016. This included identified risks of slips, trips or falls, internally and externally to the unit. Identified risks included control measures in place to mitigate them and further control measures to be used if needed. A fire risk assessment review had been completed in October 2016 and risks identified had details of mitigating factors or actions required with associated timescales and staff responsible for ensuring they were completed
- Staff were able to access appropriate alarms and nurse call systems. Pagers were available for staff use and provided individual staff with a location to respond to. Staff that we spoke with told us that the alarm system worked well and they felt confident to use it.

Safe staffing

- As of June 2016, there were a total of 15 whole time equivalent qualified nurses and a vacancy for one half time qualified nurse. Vacancy levels within the service for qualified nurses had fallen from 11.5% in July 2015 to 3% in June 2016
- As of June 2016, there were 31 whole time nursing assistants and two and half whole time equivalent vacancies. The vacancy rate for nursing assistants had fallen from 22% in July 2015 to 8% in June 2016.
- The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies between April to June 2016 was 180; this was a decrease from the same period in 2015 where the number of shifts filled was 368. The number of shifts not filled by bank or agency staff during the period April to June 2016 was 22; this was a decrease again from the same period in 2015 when 51 shifts had not been filled.
- The total number of substantive staff at the Gerry Simon Clinic in June 2016 was 43. The total number of substantive staff leavers in the 12 months prior to this was 3.5 whole time equivalent, or 8%. The permanent staff sickness rate was 10% in June 2016, This was higher than the trust average and an increase from 4% in July 2015.
- The number and grade of staff on shift was estimated by the service manager and took into account staffing flexibility to undertake increased observations or work on a 1:1 basis with patients needing increased staff support.
- Staffing levels across all three wards comprised of three registered nurses and five nursing assistants on the early shift which started at 7am and finished at 2pm. Three registered nurses and five nursing assistants worked on the late shift which started at 1pm and finished at 8pm. An additional support worker worked a 'twilight' shift which started at 5pm and finished at midnight. The night shift started at 7:30pm and finished at 7:30am. Staffing on the night shift was two registered nurses and four support workers. In addition to these staff, there was an activities lead who was a registered nurse working from 9am until 5pm from Monday to Friday. The establishment levels were planned to include three qualified nurses for the morning and afternoons shifts, this took into account the need to have a qualified nurse presence on willow, sycamore and cedars ward. Qualified staff were decreased during night shifts to two but were able to spend time between the wards due to a decrease in patient activity.
- The average shift fill rates for qualified staff during the period April to July 2016 was 114% and the average fill rate for unqualified staff was 167%. Staff that we spoke to described the shift fill rates as being above 100% due to extra staff being required to safely manage patients, including those patients on high observation levels and to ensure that section 17 leave and planned activities were still able to take place.
- The service manager used bank and agency staff that were familiar with the service and patients where possible. Staffing across the three wards could be adjusted and new staff would usually work on cedar ward initially where the patient needs were less acute. Permanent staff that we spoke with told us that bank and agency staff received an induction prior to starting work on the wards and were able to provide support when staffing was low due to sickness or long term absence.
- The unit manager and deputy manager were able to move staff between the three wards to take into account gender mix and to meet the changing needs and risk presentations of the patients using the service

Requires improvement

Are services safe?

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

- Patients that we spoke with told us that there were usually staff available when needed and they were able to have 1:1 sessions with their allocated primary nurse on a weekly basis.
- Staff and patients told us that leave and activities could be cancelled due to unforeseen circumstances, including staff sickness or injuries. Staff told us that section 17 leave community leave was seen as a crucial to patient well being and wouldn't be cancelled other than as a last resort. Activities could be moved to other times in the week if staff were required for increased observations or 1:1's but this was rare due to a full time activity worker being included in the staffing team.
- Medical cover for the Gerry Simon Clinic was provided by a dedicated doctor for the service during working hours. Out of hours cover was provided by the on call doctor and shared with hallam street hospital. Staff reported no difficulties with accessing medical staff outside of core working hours. All patients were also able to access a general practitioner who specialised in learning disabilities and who attended multi disciplinary reviews and carried out physical health monitoring, including electrocardiograms and blood tests.
- At the time of our inspection, 73% of staff were up to date with mandatory training, this was below the trust target of 85%. The trust provided all staff with a mandatory training day covering information governance, confidentiality, the management of actual or potential aggression and intermediate life support. Staff that we spoke with said that the trust were pro-active in encouraging attendance at training and compliance was monitored through the trusts learning and development service. Plans were in place to increase training compliance and staff were able to choose a variety of training dates that fitted their working commitments.
- Attendance at Mental Health Act training was low. The trust provided a range of training for qualified and non qualified staff including a basic awareness for all staff, comprising a booklet and video and a training session for all qualified inpatient staff. The compliance levels at these training sessions were 45% and 56% respectively. This was below the trust target of 85%.

Assessing and managing risk to patients and staff

- During the period July 2015 to June 2016, there were 32 recorded incidents of seclusion. The trust had developed a policy for the use of seclusion facilities, updated in May 2016. The policy contained reference to the updated Mental Health Act code of practice. We reviewed 16 records relating to the use of seclusion and found them to be completed accurately in all but one case.
- The Gerry Simon Clinic reported no incidents of long term segregation being used in the twelve months prior to our inspection.
- The service manager completed a violence and aggression risk assessment in August 2016. The risk assessment identified the possibility of violence and aggression from patients using the service and set out interventions needed to manage risk and to prevent the escalation of minor incidents. Control measures and factors to mitigate the possibility of violence or aggression were identified and future dates set for outcomes and reviews of the strategies in place.
- There were 113 incidents of the use of restraint between the period July 2015 to June 2016; these involved 14 patients. Eight of the restraints were recorded as having been carried out using prone restraint. Staff that we spoke with told us that restraint was always used as a last resort. All care records reviewed had evidence of a person centred physical intervention plan completed with patients and with detailed strategies to be used in the management of actual or potential aggression.
- Risk assessments were completed by staff using recognised risk assessment tools. Nursing staff completed the sainsbury risk assessment with patients on admission to the service and these were updated following significant events or changes in risk presentation. Specialised risk assessments had been completed by psychology staff and individualised risk assessments were agreed upon following discussion with the multi disciplinary team and a review of each patients risk history. Risk assessments used included the risk for sexual violence protocol, the historical clinical risk management version three and the northgate fire setting risk assessment tool.
- A contraband and restricted items list was in use at the service for the safety of staff and patients. Items included inflammable substances, fire arms and illicit substances. A restricted items list was also in place and contained details of items subject to supervised access only. The trust had developed a policy to provide guidance for staff whilst carrying out searches of patients. The policy was available for staff via the trust intranet, ratified in April 2016 and due for review in April

2019. The search policy contained guidance for staff using the 2015 Mental Health Act code of practice, the National institute for Health and Care Excellence and the Human Rights Act 1998 and stated that all searches must be carried out using the least restrictive and proportionate principles, have clear justification and be carried out in a coordinated, dignified and respectful manner. A security protocol document provided guidance for staff on physical and procedural security. A room was also available by the reception area for staff to carry out patient searches when returning from section 17 leave. The use of these facilities meant that patients were not searched in public or communal areas and maintained their dignity and privacy.

- The trust had developed a clinical observation and engagement policy. The policy was available via the trust intranet, was ratified and agreed in May 2016 and due for review in October 2018. The policy defined the four levels of observation to be used with patients and highlighted that patient safety must be balanced with privacy and dignity when providing care. Observation levels for patients could be increased by qualified nurses and service managers and could only be decreased following a multi disciplinary review and formulation of a plan to safely manage a patients risk using the least restrictive approach
- Rapid tranquilisation was used in accordance with guidance from the national institute for health and care excellence. Rapid tranquilisation is the process of when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others and allow them to receive the medical care that they need.
- Staff were able to access guidance on making a safeguarding referral using the trust intranet. A safeguarding policy and procedure was in place and had been updated in August 2015. During our inspection, we reviewed a previous safeguarding referral made by staff at the Gerry Simon Clinic. We found that it contained detailed information, strategies used to minimise risk and evidence of effective working with local authority safeguarding structures. Incident reporting forms recorded whether any safeguarding referrals had been completed as a result of incidents. The trust provided training for the safeguarding of adults and children. Nursing assistants were trained to level two and qualified nurses were trained to level three safeguarding adults and children. At the time of our inspection, the overall compliance rate for safeguarding training was 65%. This was below the trust target of 85%.
- The hospital monitored medication management, practice and reconciliation of controlled drugs and all other prescribed drugs in collaboration with the trust's pharmacy department. Processes reviewed included checking stock medicines levels, checking correct storage of medication, in original containers provided by the trust pharmacy and ensuring processes were followed if discrepancies in medication stocks were identified. Recent reviews of the management of controlled drugs had identified issues with staff using the correct format when completing the controlled drug record book and an action plan had been produced by the pharmacy department to improve practice in this area. A matron for the forensic services had also been appointed in May 2016 with an identified role to improve training and compliance with medication reconciliation and quality and safety standards.
- Staff were aware of the need to monitor issues including pressure sores and skin viability. Staff routinely completed assessments including the waterlow scale for patients admitted to the service. The waterlow scale is a tool that gives an estimated risk for the development of a pressure sore in a given patient.
- Facilities were available for children to visit the service. Rooms suitable for child visits were located outside of the secure clinical area.

Track record on safety

- There were no never events reported by the Gerry Simon Clinic during the period July 2015 to June 2016. A never event is a serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
- The Gerry Simon clinic reported one serious incident requiring investigation during the period July 2016 to June 2015

Reporting incidents and learning from when things go wrong

- There were 301 incidents reported using the trust's electronic incident reporting system between July 2015

Requires improvement

Are services safe?

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

and June 2016. The highest number of incidents by type was physical aggression by patients to staff which totalled 85, followed by incidents of self harming behaviour by patients which totalled 39.

- All staff we spoke with were aware of their responsibilities to report incidents and were able to discuss how they would do so using the trust's electronic incident reporting system. Staff gave examples of occasions where they would report incidents including near misses, medication errors and physical or verbal abuse.
- Staff received feedback from the investigations into incidents; both internally and externally to the service. A weekly electronic bulletin was provided to all staff via the intranet and contained details of lessons learnt in other services following the investigation of incidents.
- The ward manager for the Gerry Simon clinic was able to discuss the process of incident investigation, including the use of root cause analysis and table top reviews with senior trust staff. The trust held a monthly risk and safety meeting and the learning disabilities and other core services met to discuss recent incidents and lessons learned as a result.
- Staff were given the opportunity to debrief after serious incidents. This was in the form of a 1:1, team handovers or during team supervision sessions chaired by psychology staff.

Are services effective?

Good

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

At the last inspection in November 2015 we rated effective as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

At the last inspection in November 2015 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 to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

At the last inspection in November 2015 we rated responsive 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 well-led?

Good

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

At the last inspection in November 2015 we rated well-led as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that staff were adequately compliant with mandatory training or training in the Mental Health Act. This was a breach of Regulation 18 (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.