The Oaktree Clinic, Midlands

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Insufficient evidence to rate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Inadequate

Overall summary

This practice is rated as Requires Improvement.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Insufficient evidence to rate

Are services caring? – Requires Improvement

Are services responsive? – Insufficient evidence to rate

Are services well-led? – Inadequate

How we carried out this inspection

We carried out an unannounced comprehensive inspection at Oaktree Clinic on 16 November 2022 as part of our inspection programme.

We spoke with three non-clinical staff. There were no clinical staff on site on the day of the inspection. We were unable to speak with the registered manager.

We requested information from the registered manager of the service informally and using legal powers under the Health and Social Care Act which included risk assessments, organisational policies, audits and quality improvement documents. We also requested staffing data, appraisals and supervision figures and mandatory training compliance. The manager failed to respond to these requests. Due to this failure, we were unable to inspect some areas of the service needed to undertake a fully informed inspection of the service.

There were no patients on site on the day of the inspection. After the inspection we requested contact details of patients so they could provide feedback on the service These were not supplied.

Since the inspection, the registered manager of Oaktree Clinic has begun the process to de-register the service and to de-register their status as registered manager for Oaktree Clinic.

The areas where the service **must** make improvements as they are in breach of regulations are:

The service must ensure that staff receive safeguarding training to enable them to identify when to make safeguarding referrals and how to do so. Safeguarding policies must reference current legislation and guidance. Managers must ensure staff understand their roles and accountabilities in respect of safeguarding (Regulation 13(2)).

The service must ensure it has effective clinical audits in place to enable managers to identify themes, trends or risks and monitor medication prescribing. This must include auditing the use of controlled drugs. (Regulation 12(2)(g)).

The service must ensure that all staff are trained to enable them to identify when to report incidents and how to do so. The service should ensure that staff in patient facing roles receive appropriate training to enable them to deal with patients in crisis. (Regulation 18(2)(a))

Overall summary

The service must ensure that managers have an effective system for monitoring statutory and mandatory training. (Regulation 17(2)).

The service must ensure that there are robust governance processes in place for the use of CCTV in patient areas. This should include recording the rationale for using CCTV and its' impact on patients' privacy and dignity. The service must ensure that patients are made aware that CCTV is present in clinical areas. (Regulation 17(1)).

Managers must ensure that there are effective processes in place for reviewing and updating organisational policies. (Regulation 17(2)(a)).

The areas where the service should make improvements are:

The service should take steps to address concerns raised by staff about managers not always being approachable, available or lacking compassion.

The service should take steps to address some of the concerns raised by staff about not feeling their wellbeing needs were met, and not having opportunities for career development opportunities.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector with support from a second inspector and a specialist advisor.

Background to The Oaktree Clinic, Midlands

Oaktree Clinic Midlands is a stand-alone service, for private fee-paying patients, run by Oaktree Midlands Limited and managed by general adult psychiatrist, Dr Meetu Singh.

The clinic provides medical psychiatric assessment, diagnosis, treatment and care, psychosocial interventions, physical health monitoring and occupational and court reports. It is registered to provide services to children, young adults, adults and older adults with mental health illness, learning disabilities or autism, physical disabilities, cognitive impairment and dementia.

Requires Improvement

Are services safe?

We rated the service as requires improvement for providing safe services.

Safety systems and processes

The service had some systems to keep people safe, although organisational policies and safety assessments were not all accessible to staff. We identified some concerns with safeguarding processes.

Staff told us there were building risk assessments and safety assessments in place which had recently been reviewed. However, staff did not have access to these during the inspection, and we were unable to review them. We had sight of the fire safety and health and safety policies and saw these were in order and had been recently updated.

The service used an external company to carry out staff checks at the time of recruitment and on an ongoing basis where appropriate. Managers ensured that Disclosure and Barring Service (DBS) checks were completed prior to staff starting work. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There were accurate records of DBS checks for all staff.

We reviewed a sample of mandatory training checklists for non-clinical staff and found in two records that training completion dates were blank. Staff told us they were responsible for completing training checklists themselves. We were concerned that staff could self-certify training and it was not clear what oversight managers had of training compliance.

Managers kept a log of organisational policies although most of these were password protected and could only be accessed by managers. It was not clear why service policies were not available to all staff.

The policies we reviewed did not specify review dates. It was not clear whether there was a process in place to ensure policies were reviewed, or who had responsibility for this. For example, the clinical risk assessment and management policy had not been reviewed since it was implemented in February 2015.

We had sight of safeguarding policies and found these were of poor quality and did not reference up to date legislation. The safeguarding adults' policy referenced the 'No Secrets' government white paper (2000), which was repealed by The New Care Act (2014). The policy failed to describe the additional types of abuse, such as self-neglect and modern- day slavery contained within the current legislation. The policy stated that staff should receive safeguarding refresher training every 3 years, however staff told us they had not received this. We requested safeguarding training data 3 times from the registered manager. They failed to comply with this request and therefore were could not determine if this was factually correct.

The safeguarding adults' policy also did not specify who the safeguarding lead was or who staff needed to contact for safeguarding concerns. The policy directed staff to contact a senior clinician or managing director in the event of an emergency and that the senior clinician would determine whether to inform the police or social services. This suggested that not all staff could make safeguarding referrals. Furthermore, the local authority safeguarding contact details were not listed within the policy, and it was not clear how staff would access this information. Those staff we spoke with told us they did not understand when to make safeguarding referrals or how to do so.

There was an infection prevention and control policy in place, but staff could not access this. This meant we could not assess whether the service managed infection prevention and control effectively. Nevertheless, we saw that the service used an external cleaning agency and that a cleaner had visited the site on the day of inspection. We found all rooms and office areas were clean and well maintained.

Requires Improvement

Are services safe?

The transcranial magnetic stimulation machine had an up-to-date portable appliance testing (PAT) certificate in place and was maintained according to manufacturers' instructions.

Risks to patients

The records we reviewed showed that clinicians assessed, monitored and managed risks to patient safety. Records were comprehensive and showed effective communication with GP practices. Clinicians wrote to GP practices regularly to provide updates on patients' presentation, current risks and medication.

We could not establish whether there was a system in place for dealing with surges in demand. We had sight of the current children and adolescent mental health services (CAMHS) waiting list. There were 14 patients on the waiting list, 10 of which were under the age of 6 and were too young to be referred to the service. 4 patients were on the waiting list for a reason unrelated to age. Staff told us they took action to advertise and recruit additional clinicians for patients on the waiting list. They also said they contacted patients every month to provide updates and advise them when they were likely to be assigned a clinician. However, we were concerned that the service had accepted patients that did not meet the admission criteria due to their age and placed them on a waiting list. We were not assured that the risks of these patients had been considered or addressed.

Senior staff were easily identifiable and available for staff to escalate their concerns. Those staff we spoke with told us they knew who to contact if they were concerned about patients.

Staff told patients when to seek further help. They advised patients what to do if their condition got worse. They gave examples of how they signposted patients to crisis and home treatment teams, emergency services or charitable organisations such as the Samaritans where appropriate.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Care records showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Staff routinely documented patient's referral information, diagnosis, and treatment plans.

The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Where necessary, staff referred patients back to their own GP practice for continuity of care and to ensure that physical health needs were met.

Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. There was evidence of regular referrals to other healthcare services if these were needed.

Safe and appropriate use of medicines

The service did not keep medicines on site but had reliable systems for prescribing medicines.

Patients could choose how they received their medicines. An external pharmaceutical company delivered medicines to patient's homes. Alternatively, patients could collect their medicines from local pharmacies. Staff checked that pharmacists had medicines in stock prior to collection.

Requires Improvement

Are services safe?

There were accurate and up to date records of patient's medicine collection scripts. Staff kept written prescriptions in locked cabinets. All prescriptions were logged and numbered which meant staff or clinicians could review the individual medication contained within these.

The service audited the number of prescriptions authorised by each clinician. We reviewed the audit and saw that it did not breakdown the quantity of medicines or specific drugs prescribed. We were concerned that the service would be unable to identify prescribing themes, trends or risks using this audit. Furthermore, the audit was maintained by a non-clinical member of staff and had only been implemented in June 2022. It was not clear how the service monitored prescribing prior to this.

Clinicians prescribed controlled drugs. They checked patient's identification prior to them collecting prescriptions. However, there was no evidence during the inspection, or provided by managers afterwards, to show that controlled drug prescribing was audited or monitored.

Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines. Staff arranged blood tests for those patients that needed them, and ensured blood results were uploaded to care records.

Track record on safety

We could not assess the services' safety record. We requested information from the registered manager of the service informally and using our legal powers under the Health and Social Care Act and received no response.

The manager failed to provide copies of risk assessments in relation to safety issues.

Due to not receiving the requested information we could not assess whether there was a system for receiving and acting on safety alerts or whether joint reviews of incidents were carried out with partner organisations.

Lessons learned and improvements made

We requested information from the registered manager of the service informally and using our legal powers under the Health and Social Care Act and received no response. Due to this we could not assess whether the service learned and made improvements when things went wrong.

As we did not receive information, we were unable to establish whether there was a system for recording and acting on significant events and incidents or an incident reporting policy. This was further compounded as we were unable to speak with clinical staff to establish if they understood their duty to raise concerns and report incidents and near misses.

During the inspection we were not given access to the systems for reviewing and investigating when things went wrong. Non-clinical staff told us they were unaware whether there were standardised incident forms and said incidents were discussed through internal discussions and emails. Those staff were also unaware whether there was a clinical lessons log in place or how to access this.

Managers did not provide evidence or explain how they shared lessons, identified themes and took action to improve safety in the service. Furthermore, due to the lack of information provided to us after we had requested it we could not determine how the service learned from internal or external safety events and patient safety alerts.

Insufficient evidence to rate

Are services effective?

We rated the service as insufficient evidence to rate for providing effective services.

Effective needs, assessment, care and treatment

We reviewed 6 sets of clinical notes. Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The records follow a standard psychiatric method of clinical record keeping. There were comprehensive treatment plans in place and records were regularly updated.

Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.

We were not provided with evidence requested to show that clinicians had access to guidelines from the National Institute for Health and Care Excellence (NICE). We were unable to establish whether the service had systems to keep clinicians up to date with current evidence- based practice.

Monitoring care and treatment

Due to the non- compliance with our informal and formal requests to provide information we were unable to assess whether the service used key performance indicators to monitor performance or whether the service put actions in place to improve performance in this area. We were not provided with data for treatment targets, waiting times or referrals to secondary services. Furthermore, we were unable to assess whether the service monitored these and implemented actions to improve service performance.

In addition, we were unable to determine whether the service was actively involved in quality improvement activity and staff were unable to provide us with quality improvement tools or initiatives during the inspection.

Effective staffing

In some cases, staff did not appear to have the skills, knowledge and experience to carry out their roles.

The service did not always understand the learning needs of all staff or provide them with protected time and training to meet their needs. Non-clinical staff told us they liaised directly with people in crisis. Those staff told us they had not received crisis management training and that they found some patient interactions challenging.

Non-clinical staff delivered transcranial magnetic stimulation (TMS) to patients and told us they received training to enable them to do so. We were not able to confirm this as we could not access and did not receive, when requested the training materials, policies or risk assessments associated with TMS. Therefore, we could not determine whether the treatment was delivered safely and effectively.

We did not receive information about levels of compliance with staff's clinical supervision and annual appraisals. Furthermore, we could not establish whether clinical staff received coaching and mentoring and support for revalidation. During the inspection staff were unable to provide us with appraisal and supervision data. Non- clinical staff told us they received monthly performance reviews. They spoke positively about these which they said helped identify and address their development needs.

The service did not provide evidence, as requested, of how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

Insufficient evidence to rate

Are services effective?

Coordinating care and treatment

Staff worked together and worked well with other organisations to deliver effective care and treatment.

Records that we viewed showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. In one record we saw that staff had worked with other services to arrange an attention deficit hyperactivity disorder assessment for a patient. In a second record we saw that the service had a detailed shared care arrangement in place with a GP practice. There was evidence of ongoing and effective communication with the GP practice.

Patient information was shared appropriately. The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

There were clear and effective arrangements for booking appointments. We reviewed a service guide for appointment bookings. This contained processes for booking appointments for new and existing patients, appointment validation, and how to use the services IT systems and dashboards. We could not obtain patient feedback about whether they found the appointment system easy to use.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. In the records we reviewed we saw that clinicians sought parent's consent for care and treatment for children.

Clinicians routinely sought patients' consent to share information with GP practices or other organisations.

We saw evidence that clinicians discussed the nature, purpose and side effects of medication with patients. Clinicians completed regular medication reviews.

Requires Improvement

Are services caring?

We rated the service as Insufficient evidence to rate for caring.

Kindness, respect and compassion

There were no patients on site during the inspection. We were not provided with contact details and were unable to speak with patients although this had been requested after the inspection. This meant we could not assess how staff treated patients or obtain patient feedback regarding this.

Involvement in decisions about care and treatment

We did not speak with patients and could not establish if they were as involved in decisions about their care as they would have liked.

We did not establish whether staff were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).

Interpretation services were available for patients who did not have English as a first language. Information leaflets were available in easy read or large print formats, to help patients be involved in decisions about their care.

Privacy and dignity

We did not speak with patients and could not assess whether they felt staff respected their privacy and dignity. Nevertheless, we saw during the inspection that staff followed principles of confidentiality when managing care records and patient identifiable information. However, we found concerns regarding the use of CCTV in one of the treatment rooms.

There was a camera in the clinic room used for delivering transcranial magnetic stimulation. We were concerned that patients could be recorded without their knowledge or consent. Managers did not confirm whether CCTV arrangements were documented or subject to governance processes and regular review. Furthermore, they did not provide us with a CCTV policy or confirm that a policy was in place. We were concerned that there was a lack of decision making about the use of CCTV and its' potential impact on patients' privacy and dignity. It was also not clear whether staff made patients aware of the CCTV.

The records we reviewed showed that clinical staff understood the requirements of legislation and guidance when considering consent and decision making. They supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Insufficient evidence to rate

Are services responsive to people's needs?

We rated the service as insufficient evidence to rate for providing responsive services.

Responding to and meeting people's needs

We could not determine whether the service organised and delivered services to meet patients' needs.

We were unable to speak with clinicians or managers to understand how they improved services where possible in response to unmet needs.

The facilities and premises were appropriate for the services delivered.

Timely access to the service

We could not determine and were not assured that patients were able to access care and treatment from the service within an appropriate timescale for their needs.

Patients could access the service either by referral from a healthcare professional or by contacting the clinic directly. All appointments were booked in advance.

We were not provided with service key performance indicators (KPIs) and could not establish whether patients had timely access to initial assessment, test results, diagnosis and treatment. Staff told us that appointments generally ran on time and there was cover available for sickness or surges in demand.

We were unable to speak with clinicians and could not establish whether they prioritised care and treatment for patients with the most urgent needs.

We were unable to speak with patients to obtain their feedback on whether they felt they could access care and treatment in a timely manner.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

Information about how to make a complaint or raise concerns was available and was easy to follow.

Managers did not provide us with a copy of the complaints policy, which meant we could not assess whether the policy and associated procedures were in line with recognised guidance. Managers did not provide us with complaints data, and we could not review how many complaints were received in the last year. Nevertheless, we reviewed a sample of complaints and found that they were handled satisfactorily and in a timely way. The complaints identified lessons learned and action taken by managers.

The service learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. For example, staff identified learning from a complaint which arose from an internal communication error and made changes to address this.

Inadequate

Are services well-led?

We rated the service as inadequate for well led.

Leadership capacity and capability

Due to the lack of engagement throughout the inspection process we were not assured that leaders had the capacity and skills to deliver high-quality, sustainable care.

We did not speak to managers during the inspection and could not make a judgement as to whether they had the experience, capacity and skills to deliver the service strategy or address risks to it.

Leaders were mostly visible, and staff told us they knew how to get in touch with them. However, they told us that some managers were unapproachable and lacked compassion.

There was an effective on-call system that staff were able to use and there was a call centre in place to triage calls and patient referrals.

Vision and strategy

Due to the lack of information and engagement from managers throughout the inspection process we could not form a judgement on whether the service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

We did not speak to managers and were unable to establish whether they had a clear vision or what their organisational values were.

Non-clinical staff described how the service aimed to incorporate technology into services, for example by using online systems for patients to make bookings and by using a video call option for appointments. They also told us the service mission statement was to provide accessible mental health, regardless of age, race, gender or location, and that they felt the service delivered this.

The service did not explain, what the organisational strategy was or provide us with sight of this. This meant we could not establish whether the strategy was realistic or achievable, or whether it was in line with health and social priorities across the region.

Culture

The service did not always have a culture of high-quality sustainable care. Whilst staff were proud of the work they did, this was against a backdrop of a poor culture, where learning opportunities and support were lacking and equality and diversity had not been considered.

Staff described relationships with managers as challenging and said that they did not feel respected, supported or valued. They also told us they had observed poor relationships between managers and external agencies.

Nevertheless, non-clinical staff were proud of their work. Staff interviews and care records showed that patient care was prioritised, and it was clear that staff worked hard to achieve this.

Inadequate

Are services well-led?

Staff told us they did not feel supported or listened to regarding career development aspirations. For example, staff told us they had been given duties that did not reflect their job description, but that managers had not worked with them to address this or agree solutions.

Managers did not provide evidence or explain how they supported staff to meet the requirements of professional revalidation.

We could not establish whether clinical staff were given protected time for professional development and evaluation of their clinical work.

There did not appear to be a strong emphasis on the well-being of all staff. Staff said they did not always feel supported when they were involved in a traumatic incident, complaint or investigation. They described an incident involving the deterioration of a patient's mental health. They said they did not receive support from their manager or a post incident de-brief. They also told us they did not feel confident or able to discuss the incident with their manager.

Managers did not provide us with equality and diversity training data. Those staff we spoke with told us they had not received this training or had been provided guidance on how to reduce workplace equality. Nevertheless, staff understood equality and diversity principles.

Governance arrangements

We were not assured that the managers had ensured that there were clear governance arrangements in place. We requested information three times informally and once using our legal powers. Due to the manager's failure to comply with these requests we were unable to assess whether there were clear responsibilities, roles and systems of accountability to support good governance and management.

We reviewed one shared care arrangement. We were unable to speak to managers and we were not provided with documents relating to the governance of the service.

We were not provided with team meeting minutes, and we could not review all of the organisational policies. Some organisational policies did not have review dates or referenced outdated guidance or legislation.

Non- clinical staff were not clear on their roles and accountabilities in respect of safeguarding. Staff did not have a good understanding of the safeguarding process or access to referrals information. Staff said they did not understand how to report safeguarding concerns.

We were not assured that there were clear processes in place to document and monitor the use of CCTV in patient areas.

We found concerns with statutory and mandatory training. Staff could self- certify that they had completed training and it was not clear what oversight of training compliance managers. We were not provided evidence to show that clinical staff received regular supervision or appraisals.

Managing risks, issues and performance

Inadequate

Are services well-led?

The management of risk, issues and performance did not meet the needs of the service. Staff did not have access to documents, polices and outcomes of audits to reduce risk and increase performance. We did not have sight of service risks assessments and were not provided with information to enable us to understand organisational processes to identify, monitor and address risks including risks to patient safety.

Patients' needs were fully assessed. Clinicians assessed and documented patient's risks and provided regular updates to GP practices or other stakeholders where appropriate.

Managers did not provide us with a clinical audit programme. We could not assess how audits were used to positively impact on quality of care and outcomes for patients. We had sight of one audit which we saw did not breakdown data effectively to be able to use the data for learning or to identify themes, trends or areas of risk.

Managers did not offer staff de-briefs after incidents.

Appropriate and accurate information

We were not provided with the information we requested. Throughout the inspection, and staff could also not access information relevant to their roles.

We did not review quality and operational information or establish whether this was used to ensure and improve performance.

We did not review performance information and could not establish whether this was reported and monitored, or whether management and staff were held to account.

There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Staff understood confidentiality principles and could explained how they adhered to these. They also had an understanding about the principles of information sharing for children and young people and gave examples of how they liaised with patients' parents where appropriate.

Engagement with patients, the public, staff and external partners

We could not assess how the service involved patients, the public, staff and external partners to support high-quality sustainable services.

We did not speak to managers or clinicians and could not establish whether individual concerns were encouraged, heard and acted on to shape services and culture.

Staff were unable to describe the systems in place for patients, the public, staff or external partners place to give feedback or how this was used to improve the service.

We were unable to establish whether the service completed staff surveys or whether the findings were fed back to staff.

Continuous improvement and innovation

We could not assess whether there were systems and processes for learning, continuous improvement and innovation.

Inadequate

Are services well-led?

We were not provided with quality improvement initiatives or methodologies for the service.

The staff we spoke with did not know about service improvement methods.

In the records we reviewed, the service appeared to manage complaints effectively.

We were unable to review internal or external reports to establish whether incidents were reported effectively.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure it has effective clinical audits in place to enable managers to identify themes, trends or risks and monitor medication prescribing. This must include auditing the use of controlled drugs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service must ensure that staff receive safeguarding training to enable them to identify when to make safeguarding referrals and how to do so. Safeguarding policies must reference current legislation and guidance. Managers must ensure staff understand their roles and accountabilities in respect of safeguarding.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must also ensure that managers have an effective system for monitoring statutory and mandatory training. The service must ensure that there are robust governance processes in place for the use of CCTV in patient areas. This should include recording the rationale for using CCTV and its' impact on patients' privacy and dignity. The service must ensure that patients are made aware that CCTV present in clinical areas. Managers must ensure that there are effective processes in place for reviewing and updating organisational policies.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that all staff are trained to enable them to identify when to report incidents and how to do so. The service should ensure that staff in patient facing roles receive appropriate training to enable them to deal with patients in crisis.