English Dominican Congregation Trust

St Mary's Nursing Home Margaret Street Stone

Inspection report

Margaret Street
Stone
Staffordshire
ST15 8EJ

Tel: 01785813894

Date of inspection visit:
12 January 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 13 January 2017 and was unannounced. At our previous inspection in April 2016 we found that the service was not meeting the required standards. Regulatory breaches were identified and the service was judged as inadequate and placed into special measures. We inspected the service again In September 2016 and found some improvements had been made in relation to ensuring people's safety. However there were continuing breaches of the Regulations in relation to staffing and providing people with safe care and treatment. The service remained in special measures and was kept under review.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At this inspection we found improvements had been made in all areas of the service, none of the five key questions were rated as inadequate. Therefore the service will no longer be in special measures.

St Mary's Nursing Home provides support and care for up to 58 people. At the time of this inspection 54 people used the service.

The service does not have a registered manager. Recruitment for a registered manager was on-going; in the meantime an interim recovery manager was managing and leading the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People medicines were not always managed administered stored or recorded safely. Improvements were needed to ensure a safe system of medication management was in place and was effective.

People were supported by some staff who were caring and compassionate. However, not all staff were as thoughtful or respectful as they should be when engaging with people.

Sufficient staff were available to keep people safe and meet people's care needs in a timely manner. Staff received induction, training and supervision they needed to ensure they felt able to provide care and support to people. Recruitment and vetting procedures were in place that ensured appropriate people were employed.

People were safeguarded from abuse and the risk of abuse as staff knew what constituted abuse and who to report it to.

People were supported with their care and support needs in a safe and consistent way through the effective use of risk assessments and care plans.

The principles of the MCA 2005 were followed to ensure that people consented to or were supported to consent to their care, support and treatment.

People were supported with their daily nutritional requirements. Improvement had been made to the dining experience and people were offered and provided with the level of support they required.

People were supported with a range of healthcare services. When people became unwell and needed additional support with their health staff responded and sought the appropriate guidance and assistance.

People, their relatives and representatives were involved in the planning and review of their care. People were given the opportunity to feedback on the quality of their care and actions were in place to make improvements. A complaints policy was available and people knew how to complain and who they needed to complain to.

Social and recreational activities were arranged each day, people chose whether they wished to participate or not.

People who used the service, visitors, relatives and staff told us the interim recovery manager was approachable, supportive and had implemented the changes that were needed. Staff felt well supported with their in their role.

Systems in place to monitor the quality of the service had continued to improve. The provider must now ensure the continuity of the consistent approach with monitoring the safety and quality of the service systems to ensure people are reliably provided with a safe, responsive and well led service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. People's medicines were not always managed or administered safely. Risks to people's health and wellbeing were identified and assessed, reviewed and managed in a safe or consistent way. There were sufficient staff to support people in a safe and timely way. Staff were able to recognise abusive situations and when necessary action was taken.

Is the service effective?

Good

The service was effective. The principles of the MCA and DoLS were followed to ensure that people's rights were respected. Staff had been provided with appropriate training to fully meet people's needs and promote people's safety, health and wellbeing. People's healthcare and nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring. Some staff were not always consistently respectful when meeting people, and did not always facilitate people's individual preferences. Staff were patient and kind when they supported people with their care needs.

Is the service responsive?

Good

The service was responsive. Care plans were reflective of people's current care and support needs, which meant staff had the information to support people with their needs. People told us they enjoyed the activities that were available. The provider had a complaints procedure in place and people knew how to complain.

Is the service well-led?

Requires Improvement

The service was not consistently well led. There was not a registered manager at the service. Improvements had been made in regard to providing people with a safe and quality service; however the provider must ensure the quality assurance improvements continue to provide stability and good leadership for the benefit of people who used the service.

St Mary's Nursing Home Margaret Street Stone

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The inspection took place on 13 January 2017 and was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection we looked at the information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications that we had received from the provider about events that had happened at the service. A notification is information about important events which the provider is required to send us by law. We reviewed the information we received from other agencies that had an interest in the service, such as the local authority and commissioners.

We used a range of different methods to help us understand people's experiences. We spoke with six people who used the service about their care and support and to the relatives of two people to gain their views. Some people were less able to express their views and so we observed the care and support that they received throughout the day.

We spoke with the interim recovery manager, the deputy manager, two registered nurses, two senior care staff, five care staff and a member of the ancillary team. We looked at care records for seven people to see if their records were accurate and up to date. We also looked at records relating to the management of the service including quality checks.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in April 2016 we found the provider was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014 as people were not always supported with their care and support needs in a safe way. At this inspection we found some improvements had been made but further improvements were needed in relation to the safe management of medicines.

We looked at the way that medication was stored and administered. We saw that one person was given their medicines and the nurse who administered them did not stay with the person to ensure that they had been swallowed. We saw that there was a tablet on the floor in the person's bedroom. This meant the person had not received the support they needed with their medicine and was at risk of their treatment being ineffective. The nurse told us the person usually had no problems with taking their medication and that they usually left the medicine with the person so they were able to take it when they were ready to. We did not see that a risk assessment or care plan had been completed to ensure this was a safe and effective way of administering and supporting this person with their medicines. This meant that we could not be sure that people had their medicines when needed, or that they were always administered in a safe way.

Some people were prescribed medicines that they could have as and when required. We saw some protocols for these 'as required' medicines were attached with the medication administration records (MAR), but not all. We saw the instructions for the 'as required' medicines were included in some care plans but this information was not available with the MAR. We spoke with the nurse who was able to tell us about this medicine and when it could be given, however written guidance should be readily available with the MAR and medicines. The lack of written guidance of the administration details pertinent to the individual person meant there was a risk that people would not be offered their medicines in a consistent or reliable way.

We looked at the MARs and saw there were some gaps in recordings of when medication should be administered. the lack of accurate recording meant that we could not be sure that people had received their medicines as prescribed. The nurse was unable to offer an explanation but said the omissions would be identified during the monthly audits and checks. In another record we saw that the amount of a specific medication had been recorded as a running total of the number of tablets that were stored at the service. We asked the nurse to show us this medication but they were unable to find them. We spoke with the deputy manager and the interim recovery manager who took action to find out about the missing medication. The interim recovery manager confirmed they had looked into the missing medication and offered an explanation. However, systems in place for the safe management of medicines including those returned to the supplying pharmacy or those discarded/refused should be in place.

This meant that we could not be sure that people had their medicines when needed, that they were not always administered in a safe way and that records were not always accurate. This constitutes a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) 2014 in relation to the proper and safe management of medicines.

At our previous inspection we found the provider was in breach on Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were insufficient staff to meet people's needs in a safe and timely manner. At this inspection we found significant improvements had been made as staffing levels had been assessed and there had been an increase in staff numbers.

People told us the increase in the staffing levels had a positive impact on the care and support provided to people. One person told us: "100% better since the staffing has increased". A member of care staff told us: "The staffing levels have increased, we now have the time to spend with people, and we no longer feel rushed. There is more structure on the units, it's working really well". We observed people received their care and support in a timely way, we did not see anyone was delayed in receiving the care they required. Some people who had previously been cared for in their bedrooms now accessed the communal areas regularly so reducing the risk of social isolation.

A registered nurse was allocated to work on each of the two nursing units. A third registered nurse has been allocated to work within and between the two units to support the nurses and to ensure nursing duties and tasks were completed in a timely way. We observed and the nurses told us that people who were prescribed time critical medicines now received them at the prescribed times. We saw that follow up information from various health professionals was now being attended to in a timely and swift way, thus reducing the risks of people's health deteriorating. We saw a person had recently lost weight; the nurses told us further monitoring was required to reduce further weight loss. We saw the nurses worked together, reviewed the situation and a referral was made to the dietician for further advice and guidance. A nurse told us this arrangement was working well and was beneficial to ensure people's nursing care needs were met in a timely way. This meant concerns with peoples' health was identified and action swiftly taken to reduce further risks. The interim recovery manager told us this arrangement was being trialled for six months and then will be reviewed.

Some people were resistive when care and support was needed in regard to their personal care needs. A member of staff told us when this happened they would leave the person, ensuring their safety, and return when the person was calmer. They told us this approach was effective as on their return the person would then usually accept the support that was required. We saw care and management plans were in place, they accurately reflected the conversation we had with care staff.

Some people were at risk of developing sore skin and pressure ulcers due to immobility or ill health. Care and support plans were in place with the action needed each day to reduce risks. Staff told us and we saw monitoring charts were completed following each planned intervention so that records were maintained to show the care and support provided.

People who used the service told us they felt safe. One visitor told us: "There is always someone around, we only have to ask and someone comes almost straight away". Staff we spoke with knew the signs of abuse and who they needed to report it to if they suspected someone had been abused. One staff member said they would report any concerns straight away to the managers and if they were not available then they would contact the local authority safeguarding team. The interim recovery manager was aware of their responsibility to act on any allegations of abuse or concern. We saw referrals for investigation into allegations of abuse had been made.

Staff confirmed that recruitment checks were completed to ensure they were suitable to work with people when they first started. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. The interim recovery manager told us and we saw that checks were being completed when agency staff were used to fill staffing vacancies. Staff

profiles were obtained from the agency services prior to the person working at St Mary's Nursing Home to ensure the agency staff were suitable to provide a safe service. Recruitment for care staff and a registered manager were on-going.

Good

Is the service effective?

Our findings

At our last inspection people offered very mixed views about the quality of the food provided and we saw that the then staffing levels impacted on the level of support people received in relation to ensuring good nutrition and hydration.

During this inspection people told us and we saw improvements had been made to the meals and mealtimes. People told us they enjoyed the food and had sufficient to eat and drink. One person said: "The food is improving". The interim recovery manager told us they had recent discussions with the chef and catering staff where a revised menu was being developed. We saw arrangements had been made and the dining room rearranged so to cater for people who were frail and needed staff support. Now most people used the dining areas for their meals. People were offered a choice and if they preferred meals were served to them in their bedrooms. One person told us: "I don't like to eat with other people so I have my meals here in my bedroom, I prefer that". However we noticed that two people who previously were cared for in their bedrooms were in the dining room being supported with their midday meal. Both people appeared to enjoy their meal and looked calm and relaxed. Staff told us, because of the increase in the staffing levels, they now had more time to support people and offer the opportunity for social interaction including involvement with mealtimes.

Some people were at risk of malnutrition and dehydration because of illness, frailty and reduced appetites. Risk assessments had been completed and the action needed to reduce the risk recorded. We saw people's weight was monitored on a regular basis and food and fluid charts completed each day. People received additional prescribed food supplements to support them with ensuring they received adequate daily nourishment.

Staff were provided with training opportunities to develop the skills and knowledge they required to care for people effectively. One member of care staff told us they had recently attended the dementia and challenging behaviour training session. They had found it useful as it gave them an understanding of dementia and why people become anxious at times and experience behaviours that challenge. Other sessions had been planned to ensure all staff could attend. We observed a member of staff supported a person in a skilful and knowledgably way when a person became anxious and distressed. This showed us that training was available to meet staff's learning needs and covered subjects to understand the needs of the people they supported.

Annual appraisals of staff working practice and performance were on-going for all staff with their line managers. In addition the regular one to one supervision sessions continued which offered staff the opportunity to discuss work related issues and their learning and development needs. The interim recovery manager and the deputy manager discussed the support offered to staff through these one to one meetings.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so or themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked to see if the provider was working within the principles of MCA. We saw that some assessments had been completed when people did not have capacity to make some decisions for themselves. Decisions had been made with nominated family or friends in their best interest. When we spoke with staff they had an understanding of capacity. One member of staff told us: "We have had training in mental capacity and the deprivation of liberties; it's about consent and acting in people's best interests". We saw that some people had restrictions to their liberty such as rails on their bed or systems in place to prevent them from leaving the building unsupervised. The authorisations in place did not have any conditions attached as the service was acting in the least restrictive way for people.

Some people were able to make decisions about their own care and treatment. We saw some people had spoken with their families and doctor about their end of life care. Their preferences were documented and ensured that the staff were aware of these preferences so that their needs and preferences were upheld.

People had their healthcare needs met and referrals were made to other healthcare professionals when required. When identified we saw referrals had been made to the speech and language therapists, dieticians, doctors and community nurses. The nurses told us and we saw that a referral had been sent to the tissue viability services when concerns with a person's skin had been identified. Guidance had been received from the specialists and the person's care plan updated. This showed us that additional support was requested in a timely way which ensured people's healthcare needs were met.

Requires Improvement

Is the service caring?

Our findings

At the last inspection in September 2016 we observed some caring positive interactions between staff and people who used the service but this was compromised by the lack of staff. At this inspection we again saw most staff were kind and caring, however we saw some interactions were not as caring or thoughtful as they should be. One person who used the service told us that some staff 'lack the bedside manner'. We saw some staff walked straight into some people's bedrooms without knocking and on one occasion the staff member walked into the bedroom and did not pass any comment to the person in the room. No acknowledgment to or with the person was made.

Another person told us that he had been 'persuaded' by night staff to stay in bed a while longer when they asked for support to get out of bed. The person told us they were always an early riser and liked to get up early. This showed us that some staff did not always respect and facilitate people's individual preferences.

The interim recovery manager told us of the plans to improve the awareness of staff in relation to privacy and dignity, equality and diversity and to ensure the service was more caring. The Provider Information Return (PIR) gave us more information on how this will be implemented. 'The Home plans to develop "Dignity Champions" within the next 12 months to further support staff with care delivery and enhance the quality of life of people using the service. This project will be implemented through, and in association with "Dignity in Care". As part of staff training and development, and service development, opportunity will be taken over the next 12 months to source training in "Equality and Diversity", and the Care Certificate is to be rolled out to each new staff member commencing employment'.

A visitor told us they were very satisfied with the care and support provided to their relative they told us: "I am very happy with the care my mum receives. The staff are very kind and caring and nothing is too much trouble in fact sometimes they are over kind". A person who used the service told us: "I have no complaints whatsoever everyone is kind and patient, they respect what I want to do, I only have to ask and it's provided". Another person said: "On the whole I'm looked after very well". We saw the increase in the staffing numbers has enabled the care staff to have more time to spend with people. Delays in providing support to people were minimised and people who previously were frequently cared for in their bedroom were now enjoying the companionship of other people in the communal areas. We saw two people who were cognitively and physically very frail in the communal areas, their demeanour was much improved, staff reported both people experienced and displayed less anxiety and agitation.

Most people required some level of support and help with maintaining their personal hygiene. We saw staff supported people to the bathrooms or their own bedrooms when this level of support was needed. People looked well-groomed and well cared for. Attention was given to the privacy and dignity of people when using equipment such as the mechanical hoist; we did not see anyone's privacy and dignity was compromised.

Staff told us they regularly reviewed the care and support needs of people and update the relevant documents. One staff member said: "I always try and speak with the person involved and their family during

the review process, to see if there is anything we should be aware of or any changes needed". A visitor told us they had spoken with staff when they identified a change in their relative's health and swift action taken to support the person with their individual needs. We saw that at the beginning of each shift change staff had a formal handover to ensure they were aware of any significant changes to the care and support needs of people.

Good

Is the service responsive?

Our findings

At our last inspection we found the staffing situation impacted on people's preferences not being fully met and some people experienced delays in receiving the support they needed in a timely way.

During this inspection we saw the increased staffing levels ensured people were provided with the care and support they required in a responsive and timely way. A visitor and a person who used the service told us about the swift action that had been taken when concerns with the person's welfare was raised with the interim recovery manager. The person tried to maintain their independence but found it difficult at night to access the toilet. A responsive solution was made in that a sensor light was installed in the person's room that activated the light in the ensuite when the person wished to use the facilities at night. This showed us the service was responsive to people's individual care and support needs.

A full review was on-going to update the care and support plans for everyone who used the service. People and their representatives (where this was appropriate) were encouraged to be involved. This gave people the opportunity to discuss their care and support needs. Family members of some people who used the service had provided an account of their relative's social history which included significant life events. These documents were included in the care file and were available for staff to find out information about the person. This showed us a person centred approach was being adopted, where care and support was provided in an individual way.

Social and recreational activities were arranged each day, people chose whether they wished to participate or not. People who previously were cared for in their bedrooms were now offered the opportunity to join in with the activities. Staff told us they had the time to ensure people were supported with the personal care needs so they were ready for the activities. Some people preferred to stay in their rooms and this was respected. One person told us they liked to watch day time television and did not wish to join in the group activities.

People and their relatives told us that they knew who to speak to if they needed complain. The interim recovery manager told us that all complaints and concerns were taken seriously and investigated thoroughly and included a meeting with the complainant where someone was unhappy with the service provided. The interim recovery manager went on to inform us that concerns were discussed at the various staff meetings so that they would learn from any incidents and improve their practice. The PIR gave us more information on how the service dealt with concerns and complaints, 'The Home's management team undertake daily "walkabouts" of the Home, and meets with residents to seek their views about day-to-day care and any concerns or comments they have about service provision. The Home operates an open approach to complaints resolution and facilitates an open culture whereby people (residents or visitors) are encouraged to share any concerns within an atmosphere which is collaborative and inclusive without fear of reprisal. The culture operated within and by the Home is one which exercises a duty of candour - apologising when things go wrong, looking at how and why mistakes happen and what can be done to resolve the concern, learn from the mistake and improve service delivery'. This showed us that complaints were dealt with in a positive way and that concerns people raised were dealt with in an open, transparent and honest

way.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager, the provider had made changes to the internal management structure. An interim recovery manager had been recruited for a specified period of time to effect the changes that were needed and to manage the service. People told us the interim recovery manager was approachable, supportive and had effected the changes that were needed. The interim recovery manager told us recruitment was on-going for the position of registered manager and that informal meetings with some prospective candidates had taken place. However no appointment had yet been made.

Audits and checks were being completed each month. The nurse told us that checks were regularly made in relation to medicines and that the managers check the audits each month. However, the recent medication audit and check did not identify the issues and concerns we found with the management of medicines. We found that not all 'as required' medicines had written guidance and protocols for the safe and effective use of these medicines. Agency nurses were utilised to cover the shortfalls on the duty rota for nurses and would be unfamiliar with the specific needs of individual people. They would not be aware when 'as required' medicines would be necessary for some people who may not be able to verbalise their needs. The nurses administering medicines to some people did not always observe the medicines had been taken, so some people were at risk of not having their medicines as prescribed. Records for recording the administration and storage of medicines were incomplete and lacking information to ensure a safe and effective medicines system was in place. The audit of medicines was not sufficiently robust to ensure safe and effective medicines management.

Risks to people were being identified, managed and reviewed. The falls audit looked at any slips, trips and falls people had experienced throughout the month and action was taken when any trends or patterns were identified. The interim recovery manager had identified a person who was at risk of falling and had experienced some falls; a referral was made to the falls services to obtain guidance and advice on reducing the risks to the person. The person's care and support plans had been reviewed and updated with the information of the action needed to reduce the risks. This showed us that systems were in place to identify any themes, issues or risks associated with the service provision could be identified quickly and remedial action taken

Staffing levels had been increased to a level where people were provided with a safe, effective, responsive service in a timely way. The staffing levels were determined and based on the dependency needs of the people who used the service. A new assessment tool had been implemented to obtain an accurate account of each individual's level of dependency. A revised staffing tool, based on the dependency needs of people, had been completed each month to determine the staffing levels and numbers required. The interim recovery manager confirmed the dependency assessments and the staffing tool were reviewed monthly. This meant that staffing levels were assessed as being in sufficient number to provide care and support to people who used the service in a safe and timely way.

We looked at the staffing rota and saw the increase in the staffing numbers were maintained. Without exception people, visitors and staff told us about the positive impact the revised levels had on the provision

of care and the improved quality of the service. A nurse told us: "I now have the time to complete my nursing duties in a timely way and the care staff have the time to provide good quality care without rushing". A visitor told us: "Staff are available should my relative need help". A member of care staff said: "We now have more time to spend with people". We saw the majority of people who used the service now had the opportunity to use the communal areas, and join in the activities or meet with other people. There were some people who preferred to stay in their bedrooms or were being cared for in bed this was either due to their preference or because of frailty and ill-health.

Satisfaction and quality surveys were being distributed to people and their visitors. Some surveys have been returned and included their opinions about the catering and food, personal care and support, daily living, the premises and management. Some comments included: 'personal care and support is very good', 'nothing is too much trouble for the staff', and 'the home is fab, could not ask for more. The interim recovery manager told us of the plan to implement staff surveys so giving them the added opportunity to comment about the quality of the service provision. This showed us people were enabled and given the opportunity to share their views and opinions of the service.

Meetings with the various staff groups were arranged at intervals where they had the opportunity to discuss the service. In addition 'flash' meetings were held at short notice where information needed to be passed to staff quickly. Care staff told us they had recently been involved in one of the flash meetings and thought it was a good and effective way of information sharing.

Training for staff was being reviewed with various different platforms for the training being considered, for example face to face training, modular and group training. This showed us that consideration was being given to the different learning styles and preferences of the staff. Individual staff supervisions and appraisals were on-going offering staff the opportunity to speak with their line manager regarding their work performance and their learning and development needs.

We previously had concerns that people who used the service were not being provided with a safe, effective, caring, responsive and well led service. The provider supported the service by reviewing the internal management arrangements and appointed an interim recovery manager to effect the changes and provide leadership. Changes and improvements have been made to aspects of the service; however the provider must now make sure the changes are effective to ensure stability and continuity of the service so that people who use the service are safe and their well-being preserved.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have proper and safe systems in place for the management of medicines.