Methodist Homes

Sandygate Residential Care Home

Inspection report

57 Sandygate
Wath Upon Dearne
Rotherham
South Yorkshire
S63 7LU

Tel: 01709877463
Website: www.mha.org.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 6 and 13 February 2018 and was unannounced on the first day. The last comprehensive inspection took place in January 2017, when we identified a breach in the well led domain and the service was rated requires improvement. At this inspection we checked if improvements had been made. We found that the provider had failed to make or sustain sufficient improvements in this area. You can read the report from our last inspections, by selecting the 'all reports' link for 'Sandygate' on our website at www.cqc.org.uk.

Sandygate is a care home. People living in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Sandygate can accommodate up to 54 people. At the time of our inspection 49 people were using the service.

At the time of our inspection the service did not have a registered manager. 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. At the time of our inspection the home had a manager in post who had commenced their employment at the service in November 2017. The manager was not registered with Care Quality Commission, but had commenced the registration process.

We found risks had been identified and measures put in pace to manage the risk. However, we found the risks were not always managed so people were at risk of harm. We found risk assessments did not always contain enough detail to help prevent the risk occurring. This showed the registered provider was not doing all that was reasonably practicable to mitigate risks associated with people's care and treatment.

The registered provider did not always ensure that safe arrangements were in place for managing medicines. We found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. However, whilst protocols were in place to guide staff in how these should be administered, they lacked detail of what signs to be aware of prior to administering them. The temperature of the room upstairs, which was used to store medicines was not monitored or recorded to determine that they maintained the required temperatures. We also saw that eye creams and ointments were not always dated when opened. These medicines required disposal after four weeks of being opened.

We found some areas of the home were not kept clean and infection prevention and control policies were not adhered to. For example, store rooms were not always well organised. Some had items stored on the floor, which meant they were difficult to clean. One sluice area had shelves which were showing bare wood and therefore making them difficult to clean.

We observed staff interaction with people who used the service and found there was enough staff available to meet people's needs in a timely manner. Staff we spoke with felt they worked well as a team and had enough staff working with them to support people appropriately.

Staff had received training to give them the knowledge and skills to carry out their roles and responsibilities. However, some staff had not received appropriate support, supervision and appraisal in line with the registered provider's policy.

Staff were aware of how to report safeguarding concerns and use the whistle blowing policy if required.

Decisions made where people lacked capacity did not always follow best practice and did not evidence decisions were made in a person's best interest. This did not meet the requirements of the Mental Capacity Act 2005.

People who used the service received appropriate support to eat and drink sufficient amounts to maintain a healthy and balanced diet. Meals we observed looked appetising and well presented. However, we observed lunch on the first day in both dining rooms and found the people living on the upstairs unit had a better experience than those on the downstairs unit. This was due to many people requiring assistance and staff not being able to provide this support to everyone at the same time.

People who used the service had access to health care professionals as required. However, advice given by health care professionals was not always followed appropriately.

Staff interacted well with people who used the service and were caring in nature. The home had a calm and relaxed atmosphere and staff and people had a good relationship. Staff respected people's privacy and dignity.

We found people did not always receive care that was responsive to their needs. Care plans we looked at contradicted each other and were not always followed in line with peoples current needs.

All the people we spoke with knew how to raise a complaint and said they felt comfortable speaking with the manager or any of the staff.

We found that there had been a lack of consistent managers and a lack of provider oversight and governance which had contributed to the decline of the service. Audits in place to monitor the quality of service provision did not always take place in line with the registered provider's policy. Where audits had taken place they were not effective and did not always identify the concerns we had raised as part of this inspection. Some concerns were highlighted as part of the audit process but there was no evidence that sufficient action had taken place to correct them.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 9; Person-centred care, Regulation 11; Need for consent, Regulation 12; Safe care and treatment, and Regulation 17; Good governance. You can
see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to the more serious concerns found during inspections are added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Risks associated with people's care had been identified. However, we found these were not always followed.

People's medicines were not always managed in a safe way. We identified concerns regarding the storage, recording and administration of medicines.

We observed staff interacting with people who used the service and found there were enough staff available to meet people's needs. However, lunch time could have been managed better.

Staff we spoke with were knowledgeable about safeguarding people from abuse. However, concerns were not always reported to the safeguarding authority in a timely manner.

People were not always protected from the risks associated with the spread of infection. Some areas of the home required attention to ensure they did not pose a hazard.

The registered provider had a safe recruitment system in place.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the registered provider did not always work within the guidelines of the MCA. We found consent to care was not always sought in line with the law and relevant guidance.

We looked at care records and found people had access to health care professionals when required. However, advice given by health care professionals was not always actioned.

Staff received training which supported them to carry out their role. However, this was not always effective as we found concerns with medicine management, care planning and safeguarding.

People were supported to eat a well-balanced diet and food looked appetising.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed staff interacting with people and found they were supportive, kind and caring. There was a calm, relaxed atmosphere throughout the home.

Although staff were kind we found consideration had not been given to people's dining experience on the downstairs unit to ensure this was a pleasant experience for people and person centred.

We saw that staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We looked are care records and found that care plans did not always reflect people's current needs.

Social stimulation was provided to people.

The provider had a complaints procedure and managed the complaints process effectively.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found that there had been a lack of consistent managers and a lack of provider oversight and governance which had contributed to the decline of the service.

Audits in place to monitor the quality of service provision did not always take place in line with the registered provider's policy.

Sandygate Residential Care Home

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 6 and 13 February 2018 and was unannounced on the first day. The inspection was carried out by an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. We also looked at the provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke with other professionals supporting people at the service, to gain further information about the service.

We spoke with six people who used the service and five relatives of people living at the home. We spent time observing staff interacting with people.

We spoke with staff including care workers, senior care workers, the registered manager, and other members of the management team. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at seven people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

At our last inspection of 17 and 18 January 2017, this domain was rated as requires improvement. This was because it was not always evident that there were enough staff on duty. We also found that new monitoring checks to ensure medicines were administered correctly, needed to be embedded in to practice. At our inspection of 6 and 13 February 2018 we found elements of these concerns still remained.

We looked to see if people's medicines were managed in a safe way and administered as prescribed. We looked at medication administration records and found there were several gaps in the records. This meant that there was no clear account of medicines being administered as prescribed. We saw that items such as eye ointments, which should be discarded after four weeks of opening, did not have a date of opening on the bottle/tube. The prescription label on one person's eye ointment was dated 23.12.17, there was no date of opening recorded and this was still in used on our inspection dated 13.02.18. The ointment stated this should be discarded after 4 weeks. There was no way of checking when this had been opened.

We looked to see if medicines were stored securely and appropriately. We saw that medicine trollies containing medicines belonging to people living on the upstairs unit were stored in a room labelled 'pad store.' This room had been converted in to an office area and the two trollies for the unit were stored in there. No temperatures were taken of the room to ensure the room remained at a correct temperature for storing medicines. Medicines belonging to people living on the downstairs unit were stored correctly. Medicines requiring cool storage in a fridge and controlled medicines were stored in the medicine room downstairs and temperatures were taken of the fridge and the room.

People requiring medicine on an as and when basis, known as PRN did not have detailed PRN protocols in place. These did not detail when the medicines should be given and what signs to look for especially for people living with dementia. For example, one person living with dementia required pain relief on a PRN basis. The protocol in place had a section regarding what signs, body language to look for. However these were not completed. PRN medication that had been administered did not record what result the medicine had, therefore there was no measure in place to check if the medicine had worked.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff interacting with people who used the service and found there was enough staff available to meet people's needs. However, we observed lunch on both units on the first day of our inspection. We saw people on the downstairs unit had to wait for assistance after they had been given their meal. This meant their meal was going cold until someone was free to assist them. Staff on the unit were busy assisting other people to eat their meal. We found the staff could have been more organised and deployed better so that people were able to enjoy their lunch.

Risk assessments were poorly completed and were not always followed. For example, one person had a risk assessment in their file which stated they needed bed rails as they were prone to rolling out of bed. The

person's relative told us that they couldn't understand why their relative's bed rails were strapped down when they had been assessed as requiring them. When we checked their care plan the risk assessment was in place, this directed the need to use bed rails. We checked the bed and found the bed rails were tie wrapped down preventing them from being used. The person had rolled out of bed the previous night and injured their elbow. The manager told us this had been a directive from the regional support manager who had instructed that no one in residential care could have bed rails as this was a nursing need. We reported this to safeguarding following our first day of inspection. Following our inspection the manager reported they had immediate taken action to address this.

Another person had seven falls all in the bedroom falling out of bed and being found on the floor. The provider had referred this person to the falls team. The falls team had provided advice however we found this had not always been followed to protect the person and reduce the risk of further falls. This showed the staff did not take appropriate advice from healthcare professionals.

For another person who was receiving treatment from health care professionals, we found that staff had alerted a concern to the healthcare professional and the persons care needs subsequently changed. Although staff had alerted the healthcare professional, they had not reported this to the safeguarding team or to CQC. We also found the persons care plan, records and risk assessment had not been updated and their legs were not being elevated in line with the recommendations from the healthcare professional. We also found this person had three falls during January and February. The management team told us that their system alerted them when someone had two or more falls. This had generated a cause for concern report which was not followed up and the person had not been referred to the falls team to look at how falls could be prevented.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service and they told us they felt safe living at the home. One person said, "Yes I'm safe, I've been here seven years." A relative we spoke with said, "We've no qualms about the place at all." Another family had been notified as they arrived at the home that their relative had a fall the night before, they were concerned that their relative used to have bed rails but these had been taken out of use. They went on to say, "It's just a one off, we're not afraid for him. It's a lovely place."

We spoke with staff and they were knowledgeable about how to safeguard people from abuse. However, we identified some concerns during our inspection which had not been referred to the safeguarding authority until we raised them with the manager on our inspection. Although staff knew the procedures they were not always followed putting people at risk.

People were not always protected from the risks associated with the spread of infection. Some areas of the home required attention to ensure they did not create a hazard. We conducted a tour of the home with the manager and found that the home was generally clean and tidy. However, store cupboards had items stored on the floor which prevented the floor to be kept clean. Sluice areas had shelving which had worn and was creating a surface which could not be cleaned effectively. We also found a toilet which was in need of replacing as there was a tough stain on the base of it which could not be cleaned. The registered provider actioned these areas and they had been addressed when we went back on the second day of inspection.

The registered provider had a system in place to monitor accidents and incidents within the service. The system requires information to be entered electronically and triggers a cause for concerns for multiple issues such as repeated falls. If an accident is serious then the administration manager informs head office

who oversees any actions. This was a new system and still required to be embedded in to practice. During our inspection we found that some accidents had not been followed up. This meant that some people may not be referred to other professionals such as the falls team when they had persistent falls.

We saw the service had a safe procedure in place for recruiting new employees. We looked at four staff files and found the recruitment process had been followed. Pre-employment checks were obtained prior to new staff commencing employment. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people.

Staff files we viewed also showed that an induction had taken place with new employees who included training, and working alongside experienced staff for at least two shifts.

Requires Improvement

Is the service effective?

Our findings

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 for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When people 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the registered provider did not always work within the guidelines of the MCA. We found consent to care was not always sought in line with the law and relevant guidance. We looked at care records and found they included a mental capacity assessment and best interest decision for personal care. However, there were no best interest decisions for things such as the use of bed rails. For example, one person had a risk assessment in place for bed rails, the person was living with dementia and a generic mental capacity assessment had been completed. This stated the person lacked capacity. However, there was no specific best interest decision in place regarding the use of bed rails. Another person was administered their medicines covertly, but had no best interest decision in place, however, the provider had a letter from the GP to state this could be done.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service and they felt staff were understanding and knew how to support them.

We spoke with staff and they confirmed they had completed a range of training, both via eLearning and some classroom taught. We saw a training record which detailed training undertaken. This included mandatory training such as health and safety, moving and handling, infection control, safeguarding and equality and diversity. Other topics specific to staff roles were also completed for example dementia training. However, training was not always effective as we found concerns with medicine management, care planning and safeguarding.

We spoke with staff and they told us they had not received supervision sessions from their line manager for a while. Supervision sessions were one to one meetings with their line manager, to discuss work related issues. We looked at staff records and found that some staff had only received supervision once a year, dating back to 2015. This was not in line with the registered provider's policy, which was four times a year. However, staff told us they felt supported by their managers and could speak with them if required.

We looked at care records and found people had access to health care professionals when required.

However, advice given by health care professionals was not always actioned. For example, one person had been referred to the speech and language therapist (SALT) as they were losing weight. The SALT team visited and recommended the person was weighed on a weekly basis and foods offered were to be fortified and recorded on a food and fluid chart. They also recommended that the home should refer back to the SALT team if the person continued to lose weight. We found that the person was weighed monthly; food and fluid charts were poorly completed with no evaluation. Despite the person continuing to lose weight they were not referred back to the SALT team. This meant that some people did not benefit from ongoing health care support.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to eat a well-balanced diet and food looked appetising. One person said, "The food is quite good and there's plenty of it too." Another person said, "From my room I can smell the meat cooking when it's being done slowly over night. Its smells good and it keeps me going until dinner time."

We observed the lunch time meal on both units on the first day of our inspection. The meal time experience upstairs was good. Staff interacted well with people and there was a lot of friendly chatter and a nice environment. However, on the downstairs unit, all staff present in the dining area were assisting people to eat their lunch. Some other people required minimal support and prompting to eat. This assistance was not readily available and led to people's meals going cold while they waited for assistance. This could have been managed better.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who used the service and their relatives and they said they felt the staff provided a caring environment. One person said, "I'm comfortable here and that's what counts." Another person said, "The staff are caring and lovely."

We observed staff interacting with people and found they were supportive, kind and caring. There was a calm, relaxed atmosphere throughout the home. We observed staff respecting people's privacy and dignity. For example, one person asked a care worker to apply cream whilst they were still in the lounge. The care worker very patiently explained the need to go to the bathroom whilst the cream was applied. This ensured that the person's dignity was respected.

Another person did not respond to a male care worker when offering drinks and snacks. The care worker asked one of the female care workers to take over and the person took the drink and snack from them. This showed the staff worked well as a team to ensure people were supported in line with their preferences.

We observed staff interacting with people and we found that they respected people and maintained their dignity. Staff closed doors when delivering personal care and most staff spoke quietly when asking people something of a personal nature.

However, we saw one person was in their bedroom eating toast and tea. It was very cold in the room and we asked the person if they were warm enough. The window had been opened wide. The person told us they were very cold so we closed the window. A member of staff came in and said how cold the person was. We informed the care worker that someone had left the window open. This showed lack of thought from the person eating their breakfast in their bedroom.

We also observed lunch on the downstairs unit and found staff did not respond to people in a timely manner. This led to people having to wait a while before they were assisted with their meal.

We spoke with people who used the service and their relatives and they told us they felt supported to maintain their relationships. People's relatives told us that they could visit without unnecessary restrictions and felt part of their relatives care. We saw that people's bedrooms were personalised and relatives had brought in personal items and photos to ensure their relative's room was familiar.

Requires Improvement

Is the service responsive?

Our findings

We looked are care records and found that care plans did not always meet people's current needs and were contradictory in places. For example, one person had a care plan in place for mobility and dexterity which indicated they required the use of a zimmer frame to mobilise around the home. The care plan for maintaining a safe environment stated that the person walked unaided. According to accident reports this person had experienced three falls but only one of these had been recorded in the person's falls diary. The person had previously been referred to falls team in November 2017, but not following the three recent falls. This meant the risk was not managed.

Another person had a risk assessment in place for the use of bed rails. However, this did not feature in the persons care plans. This could lead to inconstant care being provided which may not meet the person's individual needs.

Another person had a sensor mat in place but this was not mentioned in the persons care plan. The care home team advised removal of floor sensor and advised a bed sensor instead but we found the floor sensor and the bed sensor was in place. Reading the care plan it was not clear what the persons needs were and how care should be provided. This put them at risk of receiving unsafe care.

We looked at another person's care plan regarding support they required with food and nutrition. The care plan stated that the person could eat and drink independently. However we observed lunch and found the person required full assistance to enjoy their meal. We spoke with staff who confirmed the person could no longer eat and drink without assistance. This meant the care plan did not meet the person's individual needs.

Care plan evaluations were not consistently completed and when they were recorded they lacked detail.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider employed an activity co-ordinator. However, they were not on duty on the days of our inspection. However, people were still enjoying activities and were engaged in playing dominoes and listening and dancing to music. The registered provider employed a Chaplin who was in the home on the day of our inspection. They spent time chatting with people on a one to one basis and provided a church service on each unit. We observed staff and residents deeply involved in a dominoes tournament. It was nice to see how much people enjoyed this. One person told us they had access to the library service who provided talking books.

The registered provider had a complaints procedure which was displayed in the entrance of the home. The manager kept a log of complaints, along with the outcome. This showed that complaints had been appropriately managed when they had been received. There had not been any recent complaints.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in January 2017, this domain was rated as requires improvement. The systems in place to monitor the quality of service provided, did not always identify and address shortfalls in a timely manner. The registered provider was required to address these issues and sent us an action plan telling us how these would be addressed.

At our inspection of 6 and 13 February 2018 we found the registered provider had not taken sufficient action to ensure these shortfalls had been addressed.

At the time of our inspection the service did not have a registered manager. 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. At the time of our inspection the home had a manager in post who had commenced their employment at the service in November 2017. The manager was not registered with Care Quality Commission, but had commenced the registration process.

There had been changes within the management team and this had impacted on the service. The last manager left the service in June 2017. The deputy manager took over the running of the service but also left a few months later. The home was then supported by two registered managers of local Methodist Homes, whilst still maintaining overall responsibilities for the home they were registered for.

In September 2017 the registered provider changed the post of administrator to administration manager. The purpose of this was to ensure the manager had support and could concentrate on managing the staff and ensuring people's needs were met. The administration manager was responsible for completing such things as some audit, notifications and internal reporting to the registered provider.

We found there was no effective governance in place and nobody had oversight of the home. The registered provider had systems in place to monitor the quality of the service; however, these were not being implemented effectively. Audits within the home were lacking and when they were completed raised concerns which were not actioned effectively. For example, a medication audit had been completed in December 2017 highlighting similar concerns to what we raised on inspection, yet they were still occurring. The infection control audit had not identified the environmental issues we raised with the registered provider. The manager informed us that they audited ten percent of care plan a month. However, issues we found had not been identified.

Staff had not received regular supervision sessions although they felt they could talk to the manager. Records showed that staff had received an average of one supervision session per year since 2015. In 2017 staff had an appraisal but no other formal one to one session.

The registered provider had a system in place to log accidents and incidents and monitor any trends and

patterns. Any incident forms were uploaded on to the electronic system by the administration manager. If the incident was serious the registered provider was made aware and monitored the outcome. The system also alerted trends such as falls. Where people had experienced more than two falls this flagged up in red. The administration manager then printed off a cause for concern report and asked the care team to action. However, there was no timeframe of when these actions were required to be met and no one took responsibility for ensuring they were actioned appropriately. Not all incidents were recorded so it was not accurate or effective.

The manager was also unaware of what cause for concern reports had been issued, when they needed to be returned or what actions had been taken as a result. We spoke with the management team and were informed this was a new system. We had already identified that it was not effectively fulfilling its purpose.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the manager sent us an email to confirm what action had been taken to address the immediate concerns. We were informed that all audits would have action plans in place and the registered provider told us they were currently working on a system to ensure they had a process of tracking outstanding actions. We were also informed that staff would be attending care plan training and senior care workers would be completing further medication training. Training would also take place regarding communication and effective documentation. The implementation of this assured us that this would reduce the risk to people who used the service.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always provided in a person-centred way which met people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not always act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality of service provided, did not always identify and address shortfalls in a timely manner.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always ensure the safe management of medicines. The provider was not always doing all that was reasonably practicable to minimise risks associated with people's care.

The enforcement action we took:

Issued warning notice