Aintree University Hospital NHS Foundation Trust

University Hospital Aintree

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Medical care (including older people's care)

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this inspection in response to concerns that were raised with us about poor staffing and patient safety on ward 25. Following these concerns being raised, the trust were unable to provide us with sufficient assurances that patient safety was being maintained and that there were sufficient arrangements to monitor the services provided on ward 25.

On 12 February 2019 we carried out a focussed unannounced inspection of ward 25.

As this was a focused inspection we did not inspect all domains therefore, this inspection had no impact on the overall rating of the trust from the previous inspection in October 2018 when we rated it as requires improvement.

Medical care (including older people's care)

We did not rate the service following this inspection, therefore the rating of requires improvement for medical care services following the previous inspection in October 2018 remained the same.

During this inspection we found the following areas that required improvement;

- Although the service had controlled infection risk well on most occasions, we found that daily cleaning checks had not always been completed, particularly for the cleaning of commodes. This meant that there was an increased risk that infection would be spread.
- Although the service had suitable premises and equipment, they had not always looked after them well. This was because controlled substances that are hazardous to health had not always been locked away and sharps had not always been managed safely.
- The service had staff with the right qualifications, skills and training to keep people safe from avoidable harm. However, there had not always been enough staff care and treatment. Records between the 1 January 2019 and 12 February 2019 indicated that the planned establishment for registered nurses had not been met on 63% of occasions during the day.
- Although controlled drugs had been managed in line with trust policy and legislation, general medicines had sometimes been left unsecured in patient areas.
- The service had not always promoted a culture that had supported and valued staff. Some staff informed us that although they had raised concerns about topics such as patient acuity or staffing, they were unaware if any action had been taken to make improvements.
- The service had not always used a systematic approach to continually improve the quality of its services. Meetings that had been held by the clinical business unit had not been minuted, meaning that it was unclear what had been discussed or what action had been taken to make improvements to areas of poor compliance.
- The service had not always collected, analysed, managed and used information well to support all its activities. We saw limited documented evidence of how information about ward 25 had been collected. We did not see documented evidence at any level of discussion about the performance of ward 25.

However, we also found the following areas of good practice;

- The service had managed patient safety incidents well. We found that all reported incidents had been investigated in a timely manner and that actions had been implemented to reduce the risk of a similar incident happening again.

Summary of findings

- Patient risk assessments and patient observations had been undertaken in a timely manner on most occasions, in line with trust policy. For example, the majority of falls risk assessments had been completed correctly.
- Staff had kept detailed records of patient's care and treatment.
- There was a clear leadership structure in place to oversee the management of ward 25.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)		Our rating of this service stayed the same. We rated it as requires improvement. We did not rate the service following this focused inspection as we were following up on concerns that had been raised with us about staffing and patient safety on Ward 25. A summary of our findings about this service appears in the Overall summary.

University Hospital Aintree

Detailed findings

Services we looked at
Medical care (including older people's care)

Detailed findings

Contents

Background to University Hospital Aintree

Aintree Hospital is a large teaching hospital in Liverpool. There are 706 inpatient beds, serving a population of around 350,000 in North Liverpool, South Sefton and Kirkby. The hospital provides care and treatment for people living in some of the most deprived areas in England.

The hospital provides a full range of acute services which include:

- Acute medicine
- Accident and emergency
- Acute frailty unit
- Surgical services

In addition to these services, the trust provides specialist services for Merseyside, Cheshire, South Lancashire, and North Wales. These specialist services include:

- Major trauma
- Complex obesity
- Head and neck surgery
- Upper gastrointestinal cancer
- Hepatobiliary
- Endocrine services
- Respiratory medicine
- Rheumatology
- Ophthalmology
- Alcohol services

The hospital is one of the largest employers locally with more than 4,800 whole time equivalent staff across the trust.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and an inspection manager. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Detailed findings

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We undertook this inspection in response to concerns that were raised with us about poor staffing and patient safety on ward 25. Following these concerns being raised, the trust were unable to provide us with sufficient assurances that patient safety was being maintained and that there were sufficient arrangements to monitor the services provided on ward 25.

During the inspection we spoke with members of staff including managers of different levels, as well as registered nurses and doctors.

We reviewed a total of eight patient paper records, five patient electronic records as well as reviewing information that was provided by the trust before, during and after the inspection.

Medical care (including older people's care)

Safe	
Well-led	
Overall	

Information about the service

The medical care service at Aintree University Hospital has 383 inpatient beds.

The hospital had 51,596 medical admissions between 1 April 2017 and 31 March 2018. Emergency admissions accounted for 22,522 (43.7%), 1,882 (3.6%) were elective, and the remaining 27,192 (52.7%) were day case.

Admissions for the top three medical specialties were:

• Gastroenterology

• General Medicine

• Cardiology

Medical services are managed by the 'medicine division' at Aintree hospital. These are divided into smaller clinical business units such as cardiology, nephrology, acute and emergency medicine, respiratory and diabetes. There are various wards and specialist services within the division including stroke services (including four hyper acute stroke beds), cardiology, respiratory, endocrinology, nephrology, gastroenterology, general medicine, endoscopy and the care of older persons.

Summary of findings

We did not rate the service following this inspection, therefore the rating of requires improvement for medical care services following the previous inspection in October 2018 remained the same.

During this inspection we found the following areas that required improvement;

- Although the service had controlled infection risk well on most occasions, we found that daily cleaning checks had not always been completed, particularly for the cleaning of commodes. This meant that there was an increased risk that infection would be spread.
- Although the service had suitable premises and equipment, they had not always looked after them well. This was because controlled substances that are hazardous to health had not always been locked away and sharps had not always been managed safely.
- The service had staff with the right qualifications, skills and training to keep people safe from avoidable harm. However, there had not always been enough staff care and treatment. Records between the 1 January 2019 and 12 February 2019 indicated that the planned establishment for registered nurses had not been met on 63% of occasions during the day.
- Although controlled drugs had been managed in line with trust policy and legislation, general medicines had sometimes been left unsecured in patient areas.
- The service had not always promoted a culture that had supported and valued staff. Some staff informed us that although they had raised concerns about topics such as patient acuity or staffing, they were unaware if any action had been taken to make improvements.

Medical care (including older people's care)

- The service had not always used a systematic approach to continually improve the quality of its services. Meetings that had been held by the clinical business unit had not been minuted, meaning that it was unclear what had been discussed or what action had been taken to make improvements to areas of poor compliance.
- The service had not always collected, analysed, managed and used information well to support all its activities. We saw limited documented evidence of how information about ward 25 had been collected. We did not see documented evidence at any level of discussion about the performance of ward 25.

However, we also found the following areas of good practice;

- The service had managed patient safety incidents well. We found that all reported incidents had been investigated in a timely manner and that actions had been implemented to reduce the risk of a similar incident happening again.
- Patient risk assessments and patient observations had been undertaken in a timely manner on most occasions, in line with trust policy. For example, the majority of falls risk assessments had been completed correctly.
- Staff had kept detailed records of patient's care and treatment.
- There was a clear leadership structure in place to oversee the management of ward 25.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Are medical care services safe?

Cleanliness, infection control and hygiene

- Ward 25 was visibly clean. We found that housekeepers were available daily and completed checklists to indicate that areas of the ward had been cleaned.
- Hand washing facilities such as sinks were available in all patient rooms and bays. In addition, hand sanitisers were available for staff and visitors to use when entering and leaving the ward. We observed staff washing their hands after each patient contact during the inspection.
- Personal protective equipment such as aprons and gloves were available for use and we observed staff using these when needed.
- During the inspection, we observed that infectious patients were managed in side rooms and staff who we spoke with were aware of this.
- All staff were compliant with 'bare below the elbow' when providing care and treatment to patients.
- Although we observed staff cleaning commodes during the inspection, the cleaning checklists had not been completed fully on any occasion between the 30 January 2019 and the 12 February 2019. For example, records for the 20 January 2019 indicated that commodes had only been cleaned on one occasion during a 24 hour period. This meant that it was unclear if commodes had been cleaned on a regular basis and that there was a potentially increased risk that infection would be spread.

Environment and equipment

- Ward 25 was located in the tower block of Aintree Hospital and was a planned escalation space used consistently at time of maximum occupancy. The ward area was secured by a locked door and swipe card access, reducing the risk that people would gain access to the ward unsupervised.
- We found that controlled substances had not always been locked away securely, meaning that there was an increased risk that they could be accessed by patients

or relatives unsupervised. For example, we found that cleaning tablets had been left unlocked in the dirty utility room. This was not in line with trust policy or health and safety legislation.

- Emergency resuscitation equipment was available and records between 1 January 2019 and 12 February 2019 indicated that this had been checked daily. In addition, we found that all emergency equipment that had been required was packaged correctly, in date and available for use. This meant that the correct resuscitation equipment would be available for staff to use in the event of an emergency.
- However, the resuscitation equipment was not tamper sealed. Tamper seals are used to seal equipment once it has been checked to assure staff that no equipment has been removed since it has last been checked. This meant that there was an increased risk that emergency equipment would not always be available in the event of an emergency in the future.
- Although there was a sepsis box which included equipment for staff to use to treat patients who had been diagnosed with sepsis, this had not been checked on any occasion since November 2018 despite there being a checklist available for staff to complete. This meant that there was an increased risk that the correct equipment would not always be available when needed.
- There were systems in place to manage and dispose of clinical and non-clinical waste. Sharps boxes were also available for the disposal of equipment such as needles and cannulas. However, sharps had not always been managed appropriately. For example, on one occasion we found that a sharps box had been left open and unattended, and on another occasion, sharps had been left unattended on a trolley in the corridor. Additionally, we found unopened cannulas and razors in a linen cupboard which had been left unlocked. This meant that there was an increased risk that patients or relatives would have access to these unsupervised.
- The linen cupboard contained a number of items which were not always stored in the correct place. For example razors and socks were stored in the same container which had been marked for socks and we found a used razor stored in a draw with other items.
- Staff informed us that equipment had been available when needed. The equipment store was well stocked and all disposable equipment had been packaged appropriately. In addition, we found that important equipment, such as pressure mattresses were available for use when patients had needed them.
- Oxygen cylinders had been stored securely against walls when not in use which was in line with trust policy as well as health and safety legislation.

Assessing and responding to patient risk

- The trust used a modified early warning score system to identify deteriorating patients which was paper based. This was based on a number of basic observations including blood pressure, heart rate and temperature. There were clear actions for staff to take depending on the modified early warning score. This included monitoring patients on a more regular basis or escalating them for an immediate medical review when needed.
- The trust had a policy which detailed how to manage a deteriorating patient and this was available on the intranet. Staff were aware of the importance to use this system correctly and informed us that they had received training on how to use it.
- Out of eight patient records, we found that patient observations had been taken in a timely manner and patient's modified early warning score had been calculated correctly on seven out of eight occasions. More importantly, when a patient's modified early warning score had increased, nurses had escalated this appropriately. This meant that patients who were at a higher risk of deteriorating had been reviewed more regularly. However, we noted that on one occasion a patient's observations had not been taken in a timely manner (records indicated that the patient's observations were an hour overdue), meaning that in this case, there was an increased risk that the patient would deteriorate without staff being aware.
- We reviewed eight sets of patient records during the inspection, finding that risk assessments for venous thrombo-embolism (a blood clot), the malnutrition screening tool and fluid balance charts had not always been completed.

- Out of eight patient records, fluid balance charts had not been completed fully on any occasion. Although there had been entries noting fluid intake and output, there was no documented evidence of these having been calculated to assess whether a patient had been at increased risk of dehydration.
- Records from a further five patient records also indicated that risk assessments for venous thrombo-embolism had been completed in a timely manner on only three out of five occasions. On two occasions, a risk assessment had only been completed between two and three days following admission.
- The malnutrition universal screening tool had been completed in all patient records that we reviewed. However, we noted that on three out of five occasions, this had not been completed in a timely manner. For example, a patient risk assessment had not been completed until five days following admission. This meant that during this time, there was an increased risk that a patient's nutritional needs would not be met.
- However, other risk assessments, such as those for falls and for pressure ulcers had been completed correctly on most occasions.
- Falls risk assessments for patients had been completed in a timely manner on admission and daily care plans for falls had been completed correctly on seven out of eight occasions. This was important as staff had documented whether a patient's mobility had changed and if any extra support had been required. However, for one patient, daily risk assessments for falls had only been completed on one out of four days. This meant that there was an increased risk that staff would not identify a change in a patient's mobility, and were therefore at greater risk of having a fall.
- On occasions when patients had been identified as being a high falls risk, they were managed in a tagged bay. This was when patients had to remain in view of a member of staff at all times.
- We also found that pressure ulcer risk assessments had been completed on seven out of eight occasions. Records indicated that patients had been repositioned in a timely manner when needed and referrals had been made to the tissue viability team when required. Additionally, bed rails risk assessments had been completed on nine out of 10 occasions.
- We found that intentional rounding had been completed in a timely manner on eight out of nine occasions that we checked. Intentional rounding is used to check regularly on patients' needs such as repositioning and assessing pain.
- Records indicated that patients had been reviewed within 12 hours of admission on all occasions and had received a daily medical review on four out of five occasions.
- Call bells were available at all patient bedsides and we found that they were in immediate reach of all patients so that they could call for assistance when needed. On occasions when patients had called for assistance, we observed staff responding in a timely manner.
- The trust had a medical emergency team who had been available 24 hours a day, seven days a week to respond to emergencies throughout the hospital. Staff were aware of how to contact the medical emergency team when needed.

Nurse staffing

- Concerns had been raised with CQC prior to our inspection that staffing levels had not been appropriate to keep people safe. We also had concerns that the trust had not been able to provide us with all assurances prior to the inspection as they did not use a system that recorded occasions when staff had been moved from different ward areas, meaning that they had been unable to provide assurances that sufficient actions had been taken on occasions when the planned nursing establishment had not been met.
- The trust had planned for there to be five registered nurses on duty during the day and three at night time. On the day of our inspection, we found that the planned establishment of registered nurses had not been met. In addition, records between the 1 January and 12 February indicated that the planned

establishment for registered nurses had not been met on 63% of occasions during the day. However, we noted that this had been achieved on all but one occasion at night.

- In addition, the planned number of healthcare assistants had been achieved on most occasions during the same period.
- The nursing establishment had been calculated using an acuity tool. Managers informed us that recruiting staff to the ward had been a consistent challenge. Records indicated that there were currently 10 vacancies for registered nurses as well as 10 vacancies for healthcare assistants.
- Managers informed us that staffing skill mix had been reviewed on a regular basis to make sure that more experienced members of staff had been available at all times. For example, three registered nurses had been provided from other ward areas to support bank and agency staff on the ward.
- Staffing had also been reviewed in daily staffing huddles that had been held by the matrons. This provided an opportunity for staff to be moved across ward areas so that shortfalls had been filled when needed. However, a formal record of any changes had not been kept.
- Staff informed us that there was a nurse handover that was held at the start and finish of every shift. We found that all staff had handover sheets which highlighted the individual requirements of each patient, such as if they were at risk of falls or infection.
- We saw evidence that local induction checklists had been completed for bank and agency staff. Local inductions are important as it provides an opportunity for staff to be orientated with the ward area and to understand what is expected of them.

Medical staffing

- We found that there were sufficient numbers of medical staff to cover medical wards that we visited at the time of our inspection. Medical rotas had been completed to make sure that there was sufficient medical cover to review patients within 12 hours of admission, in line with best practice guidance and trust policy.
- The ward had access to one substantive consultant, and arrangements had been made for additional locum consultants to be used when needed. We were also informed that three junior doctors had been allocated to the ward.
- Rotas between the 1 January 2019 and 12 February 2019 indicated that the planned number of medical staff had been achieved on all but five occasions.
- Out of hours, consultants were available on call. All staff who we spoke with informed us that consultants had been easy to contact when advice had been needed or a patient had required a review.

Records

- Patient records were a combination of electronic and paper based records. For example, diagnostic results such as blood tests were kept on the electronic system and paper based records consisted of patient observations and patient risk assessments.
- We found that all records were stored securely, meaning that patient information was kept in a confidential manner. Patient records were kept in locked nurse's offices at all times when they were not being used.
- However, it was sometimes difficult to find information within patient records as they had not been organised in a clear way. This meant that there was an increased risk that staff would not always be able to find patient information when needed.
- During the inspection, we reviewed eight sets of patient paper records. We found that seven out of eight patient records had been fully completed, were legible, dated and signed by the member of staff who had made the entry.

Medicines

- Controlled drugs had been stored securely. Records indicated that the number of controlled drugs tallied with the number that had been recorded in the controlled drugs register and that they had been checked daily, in line with trust policy and legislation.
- However, we noted that agency staff had been unable to access the electronic to record daily checks when completed. On occasions when agency staff had

checked controlled drugs, paper records had been completed. As a result, there was an increased risk that daily checks that had not been completed would go unnoticed by managers.

- General medicines had not always been stored securely. Although most medicines had been stored in a locked room, we found that some medicines had been left unsecured outside patients rooms. For example, we found a bag of sodium chloride and a packet of nebulisers left outside a patient's room. We checked a sample of general medicines, finding that they were in date.
- Fridges had been checked daily and staff had recorded minimum and maximum temperature checks to ensure that medicines were stored at the correct temperature.
- We checked four electronic prescription charts, finding that any allergies, patient's own medicines and any newly prescribed medicines had been clearly documented on all occasions. In addition, records indicated that medicines had been administered correctly in all cases.
- Patient's own medicines had been secured securely in bedside lockers. Patient's own controlled drugs had been reconciled, had been stored securely and had been recorded in the controlled drugs register.
- The ward had access to pharmacy technician support if needed. However, staff informed us that there was not a formal arrangement for this and that they had not attended the ward on a regular basis due to it being an escalation area.

Incidents

- The trust had an incident reporting and management policy which was available for staff to access on the intranet. Staff who we spoke with were aware of this and could access it if needed. Staff were able to give us examples of when they had reported an incident. However, we noted that agency staff did not have access to the electronic reporting system and had to ask a manger to report an incident when needed.
- Staff also informed us that outcomes from incident investigations had been shared once they had been completed.
- Between 1 January 2019 and 12 February 2019, a total of 28 clinical and non-clinical incidents had been reported. Records indicated that incidents had been reported, investigated and closed in a timely manner. In addition, we noted that there was documented evidence that actions had been taken to reduce the risk of similar incidents happening again.
- Between October 2018 and February 2019, there had been no reported never events for ward 25. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- During the same period, there had been one serious incident reported which met the reporting criteria set by NHS England. Records indicated that an initial review had not been completed in line with trust policy. This was because this was only completed within five days despite the trust policy indicating that initial reviews must be completed within 48 hours of the incident. This is important as initial reviews allowed staff to implement immediate actions to reduce the risk of a similar incident reoccurring while the incident was being investigated fully.
- We also reviewed the full investigation report that had been produced following this incident, finding that actions had been implemented to make improvements. Actions had owners who were responsible for completing them and there was also a timeframe for actions to be completed in.

Safety Thermometer

- Information about the number of patient harms was displayed at the entrance to the ward for staff, patients and visitors to see.
- Records indicated that between January 2018 and December 2018, 36 falls and four hospital acquired pressure ulcers had been reported.
- It was unclear as to how this information was being monitored locally and action being taken to make improvements. Staff were unable to tell us where this had been monitored and minutes of meetings when

this would usually be discussed had not been minuted, for example the performance and quality meeting, meaning that there was no documented evidence of what had been discussed.

Are medical care services well-led?

Leadership

- The trust had employed a substantive ward manager who was responsible for overseeing the day to day management of the ward and was supported by two deputy ward managers.
- A new matron had taken responsibility for the ward in January 2019. Staff informed us that prior to this, managers had not always been visible and that they had sometimes felt unsupported.
- The matron and ward manager were overseen by a clinical business manager who reported to the division of medicine.

Culture

- Staff felt that they were able to raise concerns with members of the management team when needed. However, staff had not always felt that concerns that they had raised had been listened to. For example, staff had raised concerns about the acuity of patients and staffing levels but were unaware if any action had been taken to address their concerns..
- The trust had identified a freedom to speak up guardian. Freedom to speak up guardians are important as it provides an opportunity for staff to raise concerns anonymously. Staff who we spoke with were aware of the freedom to speak up guardian and knew how to raise concerns with them if needed.

Governance

- The trust had made arrangements for the ward to be included in the governance structure for the division of medicine. This meant that there was a way for information to be shared between the ward, clinical business unit, the division of medicine as well as the executive team when needed.
- Managers knew what the governance structure was and could give us examples of when information had been escalated and disseminated when needed.
- Managers informed us that monthly review meetings had been held by the clinical business unit to review and assess performance at ward level. However, we did not see any documented evidence of this and we were informed by managers that these meetings had not been minuted. Therefore, we were not assured that any actions identified at this meeting were being captured and monitored to help improve patient care.
- We were also informed that managers from the clinical business unit attended monthly divisional meetings, which provided an opportunity to escalate any concerns about the ward.
- In our last inspection in October 2017, we found that risk assessments had not always been completed prior to new ward areas being opened. However, records indicated that a risk assessment had now been completed, meaning that all risks posed by the opening of the ward had been formally assessed.

Managing risks, issues and performance

- The trust had a risk management strategy which was available on the intranet for staff to access when needed. Managers who we spoke with were aware of this and understood the process to escalate risk when needed.
- Managers informed us that although a risk register was held at clinical business unit and divisional level, the only formal risk that had been identified for the ward had been staffing.
- Following concerns that had been raised with the CQC in November 2018 about ward 25, we were informed that performance had been monitored through the completion of weekly audits. However, the trust had not provided completed audits prior to the inspection to provide assurances that standards of care being delivered on the ward had been monitored.
- During the inspection, we found that weekly audits had only been completed since January 2019. This meant that prior to this, it was unclear how care and treatment was being monitored and improvements were being made when needed.

- We were not assured that all areas of risk and non-compliance had been escalated to the clinical business manager when needed. For example, they were unaware of areas of poor compliance with the completion of weekly audits.
- In addition, we did not see documented evidence at any level of discussion about the performance about ward 25.
- Senior managers informed us that the trust had made plans for some beds on the ward to be made permanent. However, managers who we spoke with were unaware of how many beds on the ward would be made permanent or when this would happen.

Managing information

- It was unclear how information about the ward had been collected in a way that senior managers had oversight of the ward or how information had been analysed and used to make further improvements to the service provided. This was because it was unclear how results from audits that had been completed for ward 25 had been used and how issues had been escalated if needed.
- Staff informed us that they had access to information that was required to undertake their role. There was access to computers and the intranet and staff knew how to access policies, procedures and best practice guidance.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The service must ensure that controlled substances that are hazardous to health are stored securely at all times.
- The service must ensure that sharps are managed safely, in line with trust policy at all times.

Action the hospital SHOULD take to improve

- The service should ensure that cleaning checklists are completed consistently, in line with trust policy, particularly in relation to cleaning commodes.
- The service should ensure that all equipment checks are completed when required.
- The service should ensure that fluid balance charts are completed fully for all patients, in line with trust policy and best practice guidance.
- The service should ensure that there are sufficient numbers of staff available at all times to meet the needs of patients.
- The service should ensure that all medicines are stored securely, in line with trust policy.
- The service should consider ways to capture information from meetings at all management levels.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met;** Controlled substances that were hazardous to health had not always been stored securely, meaning that there was a risk that patients or relatives would be able to access these unsupervised. Sharps had not always been managed in a safe way, in line with trust policy.