Four Seasons (No 10) Limited

Lansdowne Care Home

Inspection report

Claremont Road
Cricklewood
London
NW2 1TU

Tel: 02088308444
Website: www.fshc.co.uk

Date of inspection visit:
28 February 2017

Date of publication:
07 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 28 February 2017 and was unannounced. At our last inspection in June 2015 the service was rated as good.

Lansdowne Care Home is a service for older people who are in need of nursing care. Lansdowne Care Home provides accommodation to a maximum of ninety-two people some of who may have dementia. The home has 92 beds split into 3 units. On the day we inspected there were 91 people living in the home.

The service had a registered manager who had been in post since April 2015. 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 were positive about the service and the staff who supported them. People told us they liked the staff and that they were treated with dignity and kindness.

Staff treated people with respect and as individuals with different needs and preferences. Staff understood that people's diversity was important and something that needed to be upheld and valued. Relatives we spoke with said they felt welcome at any time in the home; they felt involved in care planning and were confident that their comments and concerns would be acted upon. The care records contained detailed information about how to provide support, what the person liked, disliked and their preferences. People who used the service along with families and friends had completed a life history with information about what was important to people. The staff we spoke with told us this information helped them to understand the person.

The staff demonstrated a good knowledge of people's care needs, significant people and events in their lives, and their daily routines and preferences. They also understood the provider's safeguarding procedures and could explain how they would protect people if they had any concerns.

Risk assessments were in place for a number of areas and were regularly updated, and staff had a good knowledge and understanding of many complex health conditions.

There were sufficient numbers of suitably qualified, skilled and experienced staff to care for the number of people with complex needs in the home.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work.

We found errors with medicines administration, recording and reviewing for some people using the service.

We have asked the provider to take urgent action to address this.

People were satisfied with the food provided at the home and the support they received in relation to nutrition and hydration.

There was an open and transparent culture and encouragement for people to provide feedback. The provider took account of complaints and comments to improve the service. People told us they were aware of how to make a complaint and were confident they could express any concerns and these would be addressed.

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 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 found that the service was working within the principles of the MCA, and conditions on authorisations to deprive people of their liberty were being met.

The management team provided good leadership and people using the service, relatives and staff told us they were approachable, visible and supportive. We saw that regular audits were carried out to monitor the quality of care.. However that the system of quality management of the service had not identified the shortfalls found during the inspection relating to the medicines.

There was one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report

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 always safe.

Medicines were not always managed safely for people and some records had not been completed correctly.

People were protected from avoidable harm and risks to individuals had been managed so they were supported and their freedom respected.

The premises were safe and equipment was appropriately maintained.

Sufficient numbers of suitably qualified staff were deployed to keep people safe.

Is the service effective?

Good

The service was effective.

People received care from staff that were trained to meet their individual needs. Staff felt supported and received on-going training and regular management supervision.

People received the support they needed to maintain good health and wellbeing.

People were supported to eat healthily.

The manager and staff had a good understanding of meeting people's legal rights and the correct processes were being followed regarding the Deprivation of Liberty Safeguards

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and caring and we observed this to be the case. Staff knew people's preferences and acted on these.

People and their relatives told us they felt involved in the care

planning and delivery and they felt able to raise any issues with staff or the registered manager.

Staff knew people's background, interests and personal preferences well.

Is the service responsive?

Good

The service was responsive. People's needs were assessed. Staff responded to changes in people's needs. Care plans were up to date and reflected the care and support given. Regular reviews were held to ensure plans were up to date.

Care was planned and delivered to meet the individual needs of people.

There was a robust complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was well led.

People living at the home, their relatives and staff were supported to contribute their views.

There was an open and positive culture which reflected the opinions of people living at the home. There was good leadership and the staff were given the support they needed to care for people.

There were systems in place for monitoring the quality of the service, however these had not had not identified the shortfalls found during the inspection relating to the medicines

Lansdowne 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 checked 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.

This was an unannounced inspection and took place on 28 February 2017.

The inspection team consisted of two inspectors, a pharmacist, a nurse advisor and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with 17 people who use the service and nine relatives. We spoke with the deputy manager, the chef, two unit managers, four nursing staff and eight care staff. We also spoke to two visiting health care professionals.

During our inspection we observed how the staff supported and interacted with people who use the service. We also looked at eight people's care records,45 medicines administration records (MARs),four staff files, a range of audits, the on-line complaints log, minutes for residents meetings, staff supervision and training records, and a number of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe whilst receiving their care and support. Comments included "dad is safe in here", "I always feel safe" and "The care is alright and I am safe."

Staff knew how to keep people safe from abuse. The staff had all received safeguarding training as part of their induction and on-going training. All of the staff we spoke with were able to tell us about types of potential abuse and how to report any allegations. They spoke highly of the training they received in relation to safeguarding and said they would report all concerns to their senior or the registered manager. They told us they were confident that the responses of managers when they reported any allegations or concerns would be supportive. A care worker told us "sometimes people are scared when you go near them, you know that something is wrong, we must report everything."

There was a safe recruitment process in place. Staff files showed that the relevant checks had taken place before a staff member commenced their employment. We saw completed application forms which included references to their previous health and social care experience, their qualifications, employment history and explanations for any breaks in employment. There was an in-date Disclosure and Barring Service certificate (DBS) on each record we looked at. This meant staff were considered safe to work with people who used the service.

There were sufficient numbers of suitably qualified staff to keep people safe and meet their needs. Staff told us there was never a feeling of being rushed in their work, one said "we have enough time to spend with people throughout the day." Our observations on the day were that we did not see staff rushing around and they were able to respond quickly to requests from those who used the service. The deputy manager told us that they used the provider's dependency care needs assessment tool to gauge staffing levels each week. This was calculated on people's individual needs and staff teams worked on specific living units to ensure people's needs were adequately met.

We also noted that the home did not use any agency staff thus ensuring continuity of care for people who used the service

People told us, "There are enough staff", "Staff numbers are OK" and "They usually respond quickly if I call" The atmosphere in the service was calm and relaxed and staff did not appear to be rushed.

We saw people's currently prescribed medicines on the Medicines Administration Records (MAR) and copy prescriptions. The allergy status of all people was recorded to prevent the risk of inappropriate prescribing. We observed a nurse during a drug round. We saw that she was very caring and took her time with residents. One resident was asleep in bed following a shower; the nurse woke her very softly, raised her bed and administered the liquid medicine with a spoon to ensure that the patient didn't choke. All the people were asked if they were in pain to determine if analgesia was needed. Most medicines were stored safely in the home in locked clinical rooms and trolleys. Temperatures were recorded daily in the clinical rooms and for the medicines fridge so that the potency of the medicines could be maintained. The provider's policy on the

handling of medicines was kept with the MAR charts; however we found that on 2 of the 3 floors the policy was out of date. We also found that the trolley on the ground floor was unlocked; the lock had been broken since 12 December 2016. This had been reported by the home to the maintenance team and supplier of the trolley and they were awaiting a new trolley. We discussed this with the deputy manager who has now confirmed that since our inspection the trolley has been replaced.

We reviewed the use of topical creams for nine people, we found that in the Topical Administration Record to the MAR chart, the directions were unclear or missing completely and the creams had not been applied as the directions had stated. For three people, the creams had not been applied on some days. We also found that the covert administration of medicines for people who used the service did not have the correct information documented and there was no date for review. It is inappropriate for covert administration of medicines to be continued without review as the needs of the person may change and the need for individual medicines may also change. When considering covert administration of medicines, the need for each individual medicine should be considered. In all of the records reviewed, there was no evidence that each medicine had been considered, instead a generic statement of 'for wellbeing' had been written. There was no evidence of a pharmacist or other specialist input detailing how medicines can be mixed safely with foods/drinks.

The evidence above demonstrates a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A robust set of policies, systems and processes was in place to manage risk and health and safety. These assessed the likelihood and potential severity of risks to the person regarding, for example, falls, bed rails, moving and handling, risk of pressure ulcers and nutrition. All were done on admission and were reviewed regularly. The risk assessments we viewed were comprehensive, clear and easy to understand.

We saw that when people had been assessed to be at high risk of developing pressure ulcers that measures have been taken to prevent them from developing them. The people at very high risk were provided with alternating pressure relieving air mattresses with good functioning profiling beds. There were accurate records of repositioning charts. These charts were kept and maintained for all the people at very high risk of developing pressure ulcers. Nurses and care staff explained how they managed and prevented pressure ulcers including the use of barrier cream. Staff showed good knowledge and skill on how to recognise any change in the skin of people and take any action required to prevent deterioration. We saw that a number of people had been admitted to the home with pressure ulcers and that they were now healing. Staff took appropriate steps by referring the person with the wound promptly to the GP and Tissue Viability Nurse. The dressings were changed and recorded in the wound assessment chart after each dressing change as instructed by the Tissue Viability Nurse. There were wound pictures taken as part of evidence to monitor the changes in the wound and to take prompt action to manage any change Wound assessments and dressings were clearly documented for each wound. We found one person's mattress was not in full working order. This was highlighted to the deputy manager (who was the clinical lead) who told us they would address this as a matter of priority.

There were arrangements in place to deal with foreseeable emergencies. We saw a "grab bag" at the nurse's station, which would be used in the event of an emergency. The grab bag contained evacuation details of each person in the home, including their means of evacuation. For example, whether they needed a wheelchair, a frame or assistance from staff to evacuate the building. This bag also contained emergency telephone numbers of senior members of staff and where people should be evacuated to.

Checks were carried out on equipment at the service to protect people from risk. Checks were completed on

bed rails, pressure mattress settings, hoists and wheelchairs. The home was currently without a dedicated maintenance person, the deputy manager told us that they were in the process of recruiting to this post; in the meantime maintenance was managed by an external contractor. We saw records of regular checks in relation to gas and electrical safety, risks from hot water and hot surfaces. We saw that external maintenance checks were made on the lift, call bell system, fire equipment and hoists to ensure they were in working order.

Good

Is the service effective?

Our findings

People told us staff had the knowledge and skills needed. One person said, "The staff seem well trained" and another told us "I think they are all well trained" and "They always tell me about any changes to my care and treatment." A healthcare professional described staff as "knowledgeable" and "good at what they do."

There was a comprehensive induction and on-going training to ensure that staff had the necessary skills and knowledge to undertake their role and fulfil their responsibilities. Staff we spoke to said they were well supported by the management and received sufficient training to their job effectively. One staff member said, "the training here is good. We have something on a regular basis."

There was a rolling programme of training available for all staff, which included, moving and handling, safeguarding adults, dignity, basic life support, first aid awareness, Dementia Care Framework, fire safety, medicines management, catheter care and pressure ulcer prevention. New staff were given the opportunity to shadow experienced staff. This helped staff to learn and understand the expectations of their role. A number of staff had been supported to attain nationally recognised qualifications in care. We saw that practical moving and handling training was carried out by a member of the nursing staff. . Some training had also been provided by outside community professionals. Examples given were the hospice nurse who came in to set up and provide training on syringe drivers; another was the dietician on the benefits of supplements and thickened fluids and how to fortify meals. Dementia training was provided by 'dementia services' a team employed by the provider.

Staff we spoke with told us they received opportunities to meet with their line manager to discuss their work and performance. One member of staff said, "I enjoy my supervisions with my manager, they help me off load."

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 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).

All of the staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were working within the law to support people who lacked capacity to make their own decisions. Staff understood the importance of assessing whether a person could make a decision and the decision making process if the person lacked capacity. They understood that decisions should be made in a person's best interests. One care worker said; "we're all here for residents we must always listen to them and explain what we are doing" DoLS referrals had been made to the relevant

authorities where appropriate.

People were always asked for their consent by staff. We heard staff using phrases like "what would you like to do" and "would you like a drink now." Staff then gave people the time they needed to make a decision. Staff knew people well and understood people's ways of communication. We looked at how the service gained consent to care and treatment. We saw throughout our inspection that staff gained consent from people before they undertook any care tasks. We saw in care plans that people and their relatives were involved in the planning of care for each person at the home. We noted people and their relatives attended review meetings where appropriate where they had the opportunity to discuss the care their relatives received.

People we spoke with liked the food provided for them. One person said, "The food's great, enough choice and portions are big enough" and another told us "The meals have been very good, no complaints." People were involved in choosing the meals on a daily basis and could request special meals if they did not like the meals suggested for any particular day. The chef confirmed they asked people daily if they wished to eat the meal on the menu, if not another meal would be prepared. People were provided with sufficient amounts of nutritious foods and drink to meet their needs. People's care files included assessments of their dietary needs and preferences. These assessments indicated their diet type and their support needs. Where people required support with eating and drinking we saw that a speech and language therapist (SALT) had assessed their needs and advised staff how these people needed to be supported.

Some people were on fortified diets to help maintain their weight. Food allergies were clearly detailed in people's care plans and kitchen staff had comprehensive records of people's dietary needs, including texture of food, and whether there were any specific cultural requirements. All of this information was reflected on a large whiteboard prominently placed on a wall in the kitchen. We found the chef to be knowledgeable about people's health and cultural needs and how this related to their preferences. We were also told, that he baked a cake for each person on their birthday, He told us they visited each floor on a daily basis to ensure what was provided was what people wanted. We saw there was a four week menu cycle and were told this changed every six months. There was also a clipboard with the daily menu on it. Added to this were each day's additional preferences as expressed by people. We also saw a list of those on an 'energy dense diet' as devised recently in training with the SALT. People's weight and nutritional intake was monitored in line with their assessed level of risk and referrals had been made to the GP and dietician as needed. There was evidence of food and fluid charts being used where appropriate and these were well filled in. We noted risk assessments had been carried out to assess and identify people at risk of malnutrition and dehydration.

People were supported to maintain good health and had access to health care support. The home had a dedicated GP who visited weekly. Where there were concerns; people were referred to appropriate health professionals. People also had access to a range of visiting health care professionals such as dentists, physiotherapists, dieticians, speech and language therapists, opticians and podiatrists. Appointments with health care professionals were recorded in the care files we looked at.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were very caring. They were also respectful of people's privacy and dignity. One person told us, "Very kind, can't complain about staff, very lucky, all are easy to talk to." And another told us "I think the staff are very good, they are kind and respectful." A relative told us, "On the whole I am pleased with the staff; they are kind and show respect, I am impressed by what I see here."

Staff were motivated, passionate and caring. We observed staff interacting with people in a caring and friendly manner. They were also emotionally supportive and respectful of people's dignity. For example, we observed a care worker speaking in Spanish to one resident of Spanish origin who had dementia; the resident clearly looked delighted and happily engaged in the conversation.

We observed that staff were respectful when talking with people, calling them by their preferred names. We saw staff knocking on people's doors and waiting for permission before entering. Staff were also observed speaking with people discretely about their personal care needs. We saw that staff spoke with people while they moved around the home and when approaching people, staff would say 'hello' and inform people of their intentions. We heard staff saying words of encouragement to people. During our observations we saw many positive interactions between staff and people who used the service. Staff spoke to people in a friendly and respectful manner and responded promptly to any requests for assistance.

We saw that staff were not task orientated and they were not rushing, but attended to people's needs in a gentle and compassionate manner. Staff were interactive, polite and communicated with people in a respectful way. We saw that staff were communicating well with one another passing on relevant information to each other regarding the care they were providing .We observed that people using the service were clean and well groomed.

We saw staff being gentle to people while supporting them with tasks such as eating, taking medicines, and personal care. Staff were patient, spoke quietly and did not rush people. We saw that if somebody refused a request to help them with their personal care, staff left them and tried again later. One staff member told us "I enjoy talking and listening to their stories, we get to know them well," and another told us "We always give people options and try to keep them independent, by letting them do what they can themselves, for example some people can wash their own face but not their body."

We saw people's care plans included information about their needs around age, disability, gender, race, religion and belief, and sexual orientation. People's plans also included information about how people preferred to be supported with their personal care. For example, care plans recorded what time people preferred to get up in the morning and go to bed at night, and whether they preferred a shower or a bath. Staff we spoke with were able to tell us about people's preferences and routines.

We saw staff offered people choices about activities and what to eat, and waited to give people the opportunity to make a choice. For example, at lunchtime, staff reminded people of the choices of food on the menu and the drinks that were available.

People were supported to maintain contact with friends and family. Visitors we spoke with said they were able to visit at any time and were always welcome.

People had access to a community advocacy project and this was advertised in the main reception of the home. This meant they had access to independent people to represent them if they had no family available.

Good

Is the service responsive?

Our findings

People's care plans confirmed that a detailed assessment of their needs had been undertaken by the manager or a senior member of staff before their admission to the service. People and their relatives confirmed that they had been involved in this initial assessment, and had been able to give their opinion on how their care and support was provided. Following this initial assessment, care plans were developed detailing the care, treatment and support needed to ensure personalised care was provided to people.

The health care professionals we spoke with told us that the service was very responsive and always promoted independence and that they were proactive and knowledgeable, especially in relation to pressure sore management

The care plans contained detailed information about how to provide support, what the person liked, disliked and their preferences. People who used the service along with their families and friends had completed a life history with information about what was important to people. The staff we spoke with told us this information helped them to understand the person.

The care plans ensured staff knew how to manage specific health conditions, for example diabetes. Individual care plans had been produced in response to risk assessments, for example where people were at risk of developing pressure ulcers. Entries in people's care plans confirmed that their care and support was being reviewed on a regular basis, with the person and or their relatives. Where changes were identified, care plans had been updated and the information passed on to staff. For example, we saw that one person had recently been able to mobilise independently as a result of marked improvement in his physical and mental health. The home worked closely with the Care Home Enhancement Support Service (CHESS) team a multi-disciplinary team provided by the local Clinical Commissioning Group to keep residents from admission to hospital.

Most people told us they enjoyed the activities on offer. One person told us, There seems to be a good programme of entertainment," and another person said, "We do have entertainment, music, bingo, exercises and we watch a few movies, but the lady is sick at the moment".

However some people told us they didn't feel there was enough activities on offer, a relative told us "Social stimulation is very poor, not catering for all needs"

We spoke to the deputy manager about activities. She told us the home employed a full time activities coordinator but she was currently on sick leave She told us activities were aimed to promote people's wellbeing by offering a lot of one to one time and provided examples of sitting and chatting with people, doing their nails, going for walks and spending time in the garden. In addition to scheduled activities, such as visits from entertainers, group activities were offered to those who wanted to participate. These included, film afternoons, group quizzes, hairdressing, massage and exercise, arts and crafts and singing. We were told that every two weeks a 'Therapy Dog' came round for people to pet.The deputy manager told us that the second activities officer post was currently vacant and that there would be an increase in activities once the

post had been recruited to.

We saw that there was a complaint policy on display in the hallway and on each unit of the home. People using the service were also provided with details of how to make a complaint within the Service User Guide provided on admission into the home. All complaints were recorded electronically and then monitored by a complaints manager based at the head office of the organisation. People told us they were aware of how to make a complaint and were confident they could express any concerns. One person told us, ""I've no complaints, nothing to complain about when I had an issue she dealt with it immediately".

We saw there had been one recent complaint made and there was a copy of how it had been investigated. Letters had been sent to the complainants detailing any action, demonstrating how changes had been made and how the provider had responded.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was not available on the day of our inspection, we spoke to the deputy manager who told us she had worked for the home for many years and that it was "like a family".

We saw evidence that a comprehensive range of audits were regularly completed by the senior staff of the home. This included care file audits, with actions to resolve identified issues being signed off by the registered manager. There were a range of daily, weekly and monthly audits that included medicines, food safety, wound analysis, bed rail safety, and observation of staff practice and health and safety matters. The auditing system involved the use of iPads to record all the information which could then be transferred electronically to a centralised system, with both the registered and regional manager having direct access to this information. When we spoke with the deputy manager of the service it was acknowledged that the system of quality management of the service had not identified the shortfalls found during the inspection relating to the medicines.

We recommend that the provider takes appropriate action to ensure that the quality audit monitoring systems are used effectively and identify any areas of concern in relation to medicines management.

People who used the service and staff we spoke with praised the managers of the service and said they were approachable and visible. The deputy manager confirmed that being 'on the floor' provided her with the opportunity to assess and monitor the culture of the service. People using the service made positive comments about the registered manager, comments included, "she is very approachable, always willing to listen and take things on board." And "The manager is very pleasant and approachable, has almost an open door policy." Observations and feedback from staff and relatives showed us that there was an open leadership style and that the home had a positive and open culture.

Staff spoke positively about the culture and management of the service. Staff told us, "The managers are really good, every morning they go round and speak to the residents, " And "I can go to them any time, they are open and approachable." Staff said they enjoyed their jobs and described management as supportive. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided in one-to-one and staff meetings and these were taken seriously and discussed. A senior member of staff told us, "I really like it here, the home has a good reputation, and the managers are pleasant and knowledgeable." And another said "the manager really does care about her residents." Staff told us that they were supported to apply for promotion and were given additional training or job shadowing opportunities when required.

Mechanisms were in place for the registered manager to keep up to date with changes in policy, legislation and best practice. The deputy manager told us they were supported by the provider in their role. Up to date sector specific information and guidance was also made available for staff, and updates from the Nursing and Midwifery Council (NMC) and the care of people with dementia. The service also liaised regularly with the Local Authority and Clinical Commissioning Group in order to share information and learning around local issues and best practice in care delivery, and learning was cascaded down to staff.

We saw that there were systems in place to seek the views of people who used the service and their families and / or representatives. Satisfaction questionnaires were sent out on an annual basis, with completed ones being returned to the head office of the organisation. The results of the completed questionnaires would then be analysed. Following this, a report was then produced and made available for people living in the home to read. In the hallway of the home was an electronic iPad feedback system that any person could use to anonymously input information about how they found the service being provided. Information was checked on a weekly basis and any issues identified on the system were flagged up to the registered manager who was then required to address them.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management of medicines. 12(2)(g)