Care Quality Commission

Caireach Limited

Woodside

Quality Report

279-281 Beacon Road
Wibsey
Bradford
BD6 3DQ
Tel:
Website: www.woodleigh-care.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by people who use the services, the public and other organisations, and other information gathered by CQC, including information from our 'Intelligent Monitoring' system where available.

Summary of findings

Ratings

Overall rating for this service	Good
Wards for people with learning disabilities or autism	**Good**

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
The five questions we ask and what we found	5
What people who use the location say	9
Areas for improvement	9
Good practice	9

Detailed findings from this inspection

Our inspection team	10
Background to Woodside	10
Why we carried out this inspection	10
How we carried out this inspection	10
Finding by key questions	12
Action we have told the provider to take	19

Summary of findings

Overall summary

Woodside had previously been run by Woodleigh Care and since December 2014 has been taken over by the Cambian Group. The unit was very much in a period of change. However, staff appeared to find these new changes positive and they felt it would have a positive impact on patient care. They reported that the hospital manager was supportive and effective for all staff.

Overall patients and staff said they felt safe on the unit and we found Woodside to be effective, caring, responsive and well led.

There were sufficient staff on duty to carry out tasks, activites and physical interventions. Staff were trained in all areas to high compliance except in the area of intermediate life support.

The unit did not have a seclusion facility or low stimulation area and we found that staff's skills in de-escalation were to a high standard.

Action plans following the non-compliance at our last visit had been put in place to address our concerns. We could see that these had been monitored and driven forward to ensure progress happened. Actions from these plans were implemented and we were able to see this on the inspection.

We did find

That the controlled drugs were only being checked and signed daily by one member of staff rather than two and that the controlled drug key was held with the main drug keys. This was contravening the NMC code of practice guidelines and also Woodside’s own medicine management policy. This was immediately drawn to the attention of the hospital manager. Staff also gave patients water to consume their medication in plastic cups which were then washed between patients. This was not good prevention of infection control

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We found

- That the controlled drugs were only being checked and signed daily by one member of staff rather than two, and the controlled drug key was held with the main drug keys. This was contravening the NMC code of practice guidelines and also Woodside's own medicine management policy. This was immediately drawn to the attention of the hospital manager. The staff were also giving patients water to consume their medication dispensed in a plastic cup which was then washed up in-between patients. This was not good prevention of infection control.

We also found

- Woodside had one clinic room and the lock on the door was only accessible by the keys held by the nurse in charge, the manager and head of care. There was a couch to lie down on to be examine.
- The unit does not have any seclusion facilities, or a low stimulation area. The high staff ratio ensured that patients were de-escalated early. We observed good examples of this when a patient became highly distressed by our visit to the unit.
- Ward areas were clean and there was a cleaning schedule.
- The provider used a matrix to estimate the number of staff required for each shift.
- The unit did not use bank or agency staff instead using their own staffing.
- There were sufficient staff on duty to carry out physical interventions.
- All patients had a comprehensive risk assessment completed on admission

Are services effective?

Good

We found

- The Hospital only provided training in Intermediate life support for qualified nurses and team leaders and the compliance figures were lower than other training figures at 69%. We also identified that because there was only one qualified and one team leader per shift there may not always be an intermediate life support trained member of staff on duty. This was the case on the day of our inspection.

We also found

Summary of findings

- Care records contained up to date personalised, holistic care plans.
- Each patient also had a personal evacuation plan to assist them with leaving the building if an emergency should occur.
- There were clear records of the MDT discussions and section 132 rights being read as well as a Mental Health Act patient information leaflet.
- The assistant psychologist prepared a report for each patient for discussion at the MDT meeting.This included graphs to show medication titration as well as incidents.
- Arrangements for physical health and medical cover were good. A local GP was employed for four sessions a week and also some on call sessions
- In each of the cases we examined, treatment had been properly authorised by the responsible clinician on form T2 or by a second opinion appointed doctor (SOAD) on form T3. In one case section 62 had been used appropriately to authorise treatment pending the visit by the SOAD.
- Since our last inspection the hospital had introduced a best interests recording template. This set out the process and outcome of best interests decision making. This was also being used routinely.

Are services caring?

We found

Good

- Overall patients we spoke to gave positive feedback to us regarding staff and the unit.
- Initial referrals to the independent mental health advocate (IMHA)were made automatically for patients who lacked capacity to make the request themselves.
- Carers and families were involved in their families' care. They attended the multi-disciplinary meetings and the hospital offered open visiting arrangements.

We also found

- We reviewed the written care plans and whilst these were comprehensive, there was a lack of evidence of patients being involved in their care and treatment. The section in care plans for recording service user views was left blank in most cases

Are services responsive to people’s needs?

We found:

Good

- Food was reported to be good and the unit had recently employed a chef to cook for patients and staff.

Summary of findings

- We saw a number of examples of information for patients on notice boards, these included advocacy posters, patient community meeting times, CQC poster, how to make a phone call, how to make a complaint and a fire procedure with pictorial symbols.
- Information was available for patients who used the service and we saw easy read versions and some with pictorial symbols.
- One patient required the use of British Sign Language and Makaton. The unit had developed a core team of staff trained in these sign languages to work with the patients and this appeared to have worked well as incidents had reduced due to enabling their communication.
- All staff we spoke to were clear on the complaints procedure and how they would escalate a complaint.

Are services well-led?

Good

- With the exception of intermediate life support staff were suitably trained and compliance to mandatory training was of a high standard. We were shown a full plan of projected training throughout 2015 which included intermediate life support.
- There were no reported shortages of staff and past rotas showed few gaps in staffing. Agency or bank staff were never used.
- Audits we reviewed were infection control, T2/T3 consent to treatment, medication audit, property and environmental. These highlighted any gaps and the action needed to meet compliance.
- Action plans following the non-compliance at our last visit had been put in place to address our concerns. We could see that these had been monitored and driven forward to ensure progress happened. Actions from these plans were implemented and we were able to see this on the inspection.

Summary of findings

Wards for people with learning disabilities or autism	Good

Summary of findings

What people who use the location say

Most people who spoke to us told us that staff were caring and that they felt safe.

We spoke to people who used services individually and we were able to speak to advocacy and carers.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are trained to Intermediate life support (ILS) standard, as per policy and ensure there is an ILS trained member of staff on each shift.
- The provider must ensure that controlled drugs are checked at each handover of shift by two suitably qualified staff.
- The provider must ensure that controlled drug keys are stored on a separate key bunch to the main drug keys.

Action the provider SHOULD take to improve

- The provider should review the current staffing establishment to consider having two qualified nursing staff on day shifts.

Good practice

The assistant psychologist prepared a report for each patient for discussion at the MDT meeting. This included graphs to show medication titration as well as incidents

Care Quality Commission

Woodside

Detailed findings

Services we looked at:
Wards for people with learning disabilities or autism

Our inspection team

Our inspection team was led by:

Our inspection team was led by:

Team Leader: Patti Boden, Inspection manager, Care Quality Commission (CQC).

The inspection team consisted of:

- An expert by experience, who had experience of using mental health services
- 2 specialist advisors; a consultant psychologist and a mental health nurse.

Background to Woodside

Woodside is an independent hospital providing an assessment, treatment and rehabilitation service for up to nine adults with a learning disability and accompanying mental health problems or other complex conditions.

Woodside provides assessment and treatment programmes as well as a rehabilitation service for people who have a learning disability. People may be admitted formally, under the Mental Health Act, or informally.

On our previous inspection in January 2014 we found that the service was non compliant in three areas

- Safeguarding people who use services from abuse
- Safety and suitability of premises
- Records

On this inspection we found them to be compliant in all three areas.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme.

How we carried out this inspection

We carried out this inspection on the 23 and 24 March 2015. Our inspection was announced.

In order to carry out our inspection, we:

- Met and interviewed managers of the hospital regarding the service they provided
- Toured the ward area
- Interviewed 9 nursing staff,
- Interviewed the regional operations director and hospital manager
- Interviewed the responsible clinician (RC), consultant psychologist and assistant psychologist.
- Observed how patients were cared for on the wards.
- spoke to six patients.
- spoke to 2 carers.
- Reviewed six sets of patient care records on the ward.
- Reviewed the medication records of all patients.

Detailed findings

- Looked at the Mental Health Act (MHA) documentation of patients and reviewed the systems and processes which the service had in place in respect of those who were detained under the MHA.

Before visiting, we reviewed a range of information which we hold about the service and we asked other organisations to share what they knew. Throughout the inspection we also asked the service to provide us with a range of additional information, records and documents.

To get to the heart of the experience of people who use services we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- is it well-led?

Requires improvement

Is the service safe?

Our findings

Safe and clean ward environment

The ward layout of Woodside allowed staff to observe most parts of the ward. There were some ligature risks which were mitigated. However staff were always available in the main areas with patients as all patients were identified as requiring 1:1 staffing or higher dependant on patient need for nursing care.

Staff would easily find a ligature knife if needed. All staff carried personal alarms.

Woodside had one clinic room and the lock on the door was only accessible by the keys held by the nurse in charge, the manager and head of care. There was a couch to lie down on to be examined.

The unit had fully accessible resuscitation equipment and this included some emergency drugs and an automated external defibrillator and oxygen These were checked weekly and records were available. This equipment was stored in the main ward office so that it was accessible by all staff due to the fact that only the qualified staff had access to the clinic area.

The unit was a mixed unit but only housed one female patient. The ward complied with same sex accommodation. Since our last visit, the unit had allocated a dedicated care team to work with the patient throughout the day and night. She also had her own bedroom space and showering facilities and lockable partition to the rest of the ward bedrooms. The ward also had a separate female only lounge when required to allow her privacy, we observed this whilst inspecting. We talked to the RC and hospital manager about this issue of only one female patient. They expressed that when this patient has been moved to a suitable placement they will consider making the unit male only. This has not happened sooner due to the complex needs of this patient.

The unit does not have any seclusion facilities, or a low stimulation area. The high staff ratio ensures that staff de-escalate challenging behaviour early. We observed good examples of this when a patient became highly distressed by our visit to the unit.

Ward areas were clean and there was a cleaning schedule. The unit did not employ housekeepers and staff undertake this role. Any deep cleaning required was completed during the night and records were available. This was being done to a high standard. The unit had recently appointed a chef who was responsible for all meals being cooked on site. We found this to be excellent and the chef was visible on the unit ensuring that patients and staff got a choice of meals and menus. The chef was also responsible for keeping the main kitchen and the activities of daily living (ADL) kitchen clean and this was to a high standard.

Environmental risk assessments were completed and available for us to view, as well as records of weekly fire alarm checks. First aid kits were available and these were checked in the nurse station, main kitchen, communal kitchen and hospital vehicle. There was also a weekly key check list, hot water check and vehicle check. Alcohol hand gel was available on entrance to the units.

The latest infection control audit undertaken in February 2015 showed that Woodside were rated as green and at 90%.

Safe staffing

The provider used a matrix to estimate the number of staff required for each shift. Staffing compliment was set at 13 staff per shift during the day and six at night. This allowed staff to be on enhanced observations with some patients and those who required 1:1 staffing or higher.

We examined the rotas. There were few gaps of staffing. The unit did not use bank or agency staff instead using their own staffing. The unit only ran on one qualified staff per shift and this was then complemented by a team leader who was an unqualified member of staff with enhanced training. This team leader would organise staffing, transport, money, health and safety checks and coordination of the shift. The hospital manager had requested that her staffing be revised to increase to two qualified staff during waking hours. The hospital manager was also clear that she had sufficient authority to increase these staffing levels if the acuity of the patient group changed.

There were sufficient staff on duty to carry out physical interventions. We were able to see the frequency of incidents and also the safe hold techniques that they followed. It was clear from observing the staff with the patients that they were skilled in de-escalation and prevented most incidents before they required the use of physical interventions. 100% of staff were training in MAPA (management of actual and potential violence).

Requires improvement

Is the service safe?

Ward activities were rarely cancelled and we saw that there was sufficient staff to complete activities. These activates were planned in advance to ensure sufficient staff. There was also sufficient transport for these to be carried out.

Assessing and managing risk to patients and staff

All patients had a comprehensive risk assessment completed on admission. These risk assessments were updated monthly. All records viewed had a FACE risk profile, a positive risk assessment form and an individual physical intervention risk assessment.

All patients were detained under the Mental Health Act and were subject to restrictions.

Physical intervention was only used as a last resort and only ever used once de-escalation had failed. We saw excellent de-escalation techniques being used by staff. There were no recorded events of rapid tranquilisation or incidents of prone restraint.

Staff knew how to make a safeguarding alert and how to record this and what to do should they see something they were unsure of. We found that the unit was using a safeguarding fact finding algorithm. All safeguarding referrals to the Bradford safeguarding teams were made available to us and there was also some follow up actions. We could also see when this had been referred to the CQC.

Medication was only dispensed by qualified nurses and there was good administration and recording of daily medications. We found that the controlled drugs were only being checked and signed daily by one member of staff rather than two and the controlled drug key was held with the main drug keys. This was contravening the NMC code of practice guidelines and also Woodside's own medicine management policy. This was immediately drawn to the attention of the hospital manager. Staff also gave patients water to consume their medication in plastic cups which were then washed between patients. This was not good prevention of infection control.

Track record on safety

There were no recorded serious untoward events.

Reporting incidents and learning from when things go wrong

All staff knew what to report if an incident should occur. The incident form was always completed by the member of staff who witnessed the incident and then signed off by the team leader or nurse in charge.

Staff were open and transparent when incidents occurred and we witnessed a good example of an incident being described to the nurse in charge, the change to their daily plan and how this was communicated at nursing handover. We were also able to sit in a MDT review and see how this information was communicated to the wider team.

Staff were involved post incident debriefs and these incidents were also reviewed in staff meetings. Staff were paid for their time if they came in off duty to attend meetings.

Good

Is the service effective?

Our findings

Assessment of needs and planning of care

Care records contained up to date personalised, holistic care plans.

Care records showed that a physical examination had been carried out and each patient had a comprehensive physical care plan, which included, weight, toileting, dressing, personal care, nutrition eating and sleeping patterns. Health issues and medication.

Each patient also had a personal evacuation plan to assist them with leaving the building if an emergency should occur.

Behaviour and high risk areas care plans were well formulated and included clear risk management plans.

Psychology reports showing analysis of frequency of incidents and injuries were available and were especially helpful in the multi-disciplinary care meeting and these were utilised as a therapeutic tool with the patients.

The notes we viewed had been recently changed from Woodleigh care to reflect the change that they had been taken over by Cambian Healthcare. These care records were up to date and well ordered. All contained a staff signature recording sheet which was completed by all staff. All notes were paper records and had not moved onto electronic noting. There were different recording sections for different disciplines, for example the doctors, nurses or psychiatrists, however this was not raised as an issue by the nursing team. There were clear records of the MDT discussions and section 132 rights being read as well as a Mental Health Act patient information leaflet.

Best practice in treatment and care

We were also able to have discussions with the responsible clinician around the decision making process for choosing particular medication regimes such as Clozapine.

There were dedicated psychology services within the unit and the assistant psychologist worked closely with the clinical psychologist in developing treatment plans.

The assistant psychologist prepared a report for each patient for discussion at the multi-disciplinary team meeting and this included graphs to show medication titration as well as incidents.

The staff participated in clinical audits and some examples of these were T2/T3 consent to treatment audits, medication audits which considered all areas of dispensing managing and the use of the clinic room and property audits. These audits were all accompanied by an action plan which clearly showed the issues and action required with time scales. A recent environmental audit showed a lower than expected score at 89% and was rated as amber. This audit clearly showed the reasons for this low score and what the service had to do to improve on this.

Skilled staff to deliver care

There was a full multi-disciplinary team, which included a responsible clinician (RC), speciality doctor (who attends four sessions a week and is on call), psychologist, occupational therapist, nurses and a general manager'.

Staff had access to mandatory training. Compliance to training was mostly high, MAPA was 100%, 93% for Mental Capacity Act, 96% for moving and handling, 89% for infection control and 83% for fire and safety.

Intermediate life support compliance figures were lower than other training figures at 69%. This training was only identified for qualified nurses and team leaders. We also identified that because there was only one qualified and one team leader per shift, there may not always be an intermediate life support trained member of staff on duty. This was the case on the day of our inspection. We viewed the intermediate life support policy and this suggested that all staff should be trained to intermediate life support level and not just qualified nurse or team leaders.

Staff had access to individual supervision and staff said they felt supported. This included all professionals and not just the nursing team.

Multi-disciplinary and inter-agency team work

We observed a full multi-disciplinary team meeting, which was attended by doctors, occupational therapist, psychology and nursing staff. These meetings happened weekly and ward staff, carers and the patient were invited to attend. Staff were respectful to patients, allowed them to bring issues and the staff member was able to take information away and follow up as necessary.

Good

Is the service effective?

Arrangements for medical cover were good. The GP has a Service Level Agreement to attend two sessions per month and the service facilitates if patients need access to the GP or hospital.

We also attended a nursing staff handover which happened three times a day, morning, lunchtime and evening. All patients were discussed and tasks were allocated for the oncoming shift. We also observed the other shift and the informal handover that took place between staff when handing patients over.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- We found records of patients being routinely informed of their rights on admission.
- The independent mental health advocate (IMHA) visited routinely once a week and made additional visits to individual patients as required.
- Each of the section 17 leave authorisations we examined had been properly authorised by the responsible C. However the conditions attached to the leave were not clearly described and the leave forms were not signed by the patients. Also it was not clear which forms were current and which were out of date
- In each of the cases we examined treatment had been properly authorised by the responsible clinician on form T2 or by a second opinion appointed doctor (SOAD) on form T3. In one case section 62 had been used appropriately to authorise treatment pending the visit by the SOAD.
- In one case the record of informing a patient of his rights did not indicate whether or not the patient had understood.

Good practice in applying the Mental Capacity Act

- We found that specific issue mental capacity assessments were being routinely undertaken as required and that these were clearly recorded on the template designed for the purpose.
- Since our last inspection a best interests recording template had been introduced setting out the process and outcome of best interests decision making. This was also being routinely utilised.
- The routine undertaking and recording of specific issue mental capacity assessments and best interests assessments was evidence of good practice under the MCA.

Good

Is the service caring?

Our findings

Kindness, dignity, respect and support

Overall patients we spoke to gave positive feedback to us regarding staff and the unit. Examples of this were “has felt safe” “I like it here” “likes going swimming” “it’s clean”. Throughout the inspection to the ward, we observed staff speaking and interacting with people who used the service in a respectful manner.

The involvement of people in the care they receive

We reviewed the written care plans and whilst these were comprehensive, there was a lack of evidence of patients being involved in their care and treatment. The section in care plans for recording service user views was left blank in most cases.

The independent mental health advocacy (IMHA) service was provided by Cloverleaf and was well publicised on the ward through posters and leaflets. The IMHA visited routinely once a week and made additional visits to individual patients as required. Initial referrals to the IMHA were made automatically for patients who lacked capacity to make the request themselves.

Carers and families were involved in their families care. They attended the multi-disciplinary meetings and were also open visiting arrangements.

Good

Is the service responsive?

Our findings

Access, discharge and bed management

Discharge planning started at the point of admission. However due to the nature of the unit and the patient population patients are often there for long periods of time. They episodes of care were led clinically by the multi-disciplinary team through their weekly meeting. Length of stay varied with the longest episode being three years and four months, shortest being two months. Average length of stay was 424 days. the care team worked closely with commissioners of services to ensure that care package was appropriate for the patient and that they were not at the service for longer than required.

The ward environment optimises recovery, comfort and dignity

Woodside had a full range of rooms and equipment. There was a lounge, dining room, male and female lounges and quiet room. Some bedrooms were en-suite. There was an activities of daily living kitchen (ADL) and we were able to observe patients using this kitchen making food and drinks with support.

Food was reported to be good and the unit had recently employed a chef to cook for patients and staff.

There was adequate secure storage for patients' belongings and all cash was kept in a locked safe within the ward area. There were suitable financial arrangements in place to monitor and protect this money.

We saw a number of examples of information for patients on notice boards, these included advocacy posters, patient community meeting times, CQC poster, how to make a phone call, how to make a complaint and a fire procedure with pictorial symbols.

Patients were assisted to make private calls when needed.

All patients were on observations and staffing levels (11 staff with nine patients) were high so activities were planned on a daily basis depending on what the patients wished to do, for example supermarket shopping or the cinema. There were however some planned activities which included an off-site bakery group, gardening project, a textiles group, education and dance and drama. Patients told us that they enjoyed these groups and activities and we were able to see staff making every effort to ensure these activities took place.

Meeting the needs of all people who use the service

Information was available for patients who used the service and we were able to see easy read versions and some with pictorial symbols.

No patients required the use of an interpreter. However we were told that these could be booked as needed.

One patient required the use of British Sign Language and Makaton. The unit had developed a core team of staff trained in these sign languages to work with the patients and this appeared to have worked well as incidents had reduced due to enabling their communication.

There was a choice of food available and the unit had recently employed a chef. Patients gave feedback and said the food was "alright" , "good" and "very good cook".

Patients were able to access spiritual support as and when required.

Listening to and learning from concerns and complaints

Posters were available in the communal areas describing how patients could make a complaint. We were also able to speak to the advocacy staff on the day of our visit and we were told that all patients were fully supported to make complaints.

All staff we spoke to were clear on the complaints procedure and how they would escalate a complaint

Good

Is the service well-led?

Our findings

Vision and values

Woodside had previously been run by Woodleigh Care and since December 2014 has been taken over by the Cambian Group. The unit was very much in a period of change, however staff appeared to find these new changes positive and they felt it would have a positive impact on patient care. They reported that the hospital manager was supportive and effective for all staff.

Good governance

Staff were suitably trained. Compliance to mandatory training was of a high standard except Intermediate life support compliance figures which were lower than other training figures at 69%. This training was only identified for qualified nurses and team leaders. We also identified that because there was only one qualified and one team leader per shift, there may not always be an intermediate life support trained member of staff on duty. This was the case on the day of our inspection.

We viewed the intermediate life support policy and this suggested that all staff should be trained to intermediate life support level and not just qualified nurse or team leaders

All qualified staffs NMC pin numbers were verified and this information was made available to us via their personal files. Personal files were well organised and contained DBS checks and checks of identification.

There were no reported shortages of staff and past rotas showed few gaps in staffing. Agency or bank staff were never used.

Incidents were always reported and analysed. We saw individual reports that were completed on a weekly basis for the MDT meeting that showed past incidents and current incidents and also any spikes in behaviour, self-injury or intimate behaviour. These incidents and any learning was fedback into staff meetings and staff were encouraged to attend staff meetings when they were off duty and were paid for their time.

Audits we reviewed were infection control, T2/T3 consent to treatment, medication audit, property and environmental. These highlighted any gaps and the action needed to meet compliance.

Action plans following the non-compliance at our last visit had been put in place to address our concerns. We could see that these had been monitored and driven forward to ensure progress happened. Actions from these plans were implemented and we were able to see this on the inspection.

Leadership, morale and staff engagement

Staff felt able to raise issues without concern and they reported that they felt supported.

Staff sickness rates were variable month on month. They ranged from 2.9% to 8.8%. There was an appropriate sickness reporting procedure in place for all staff and the hospital manager explained that sickness rates were escalated and reported on.

Staff felt there was an open culture of reporting within the unit and they all reported how supported they felt in their work by the hospital manager.

There was a sense of team work in the unit and staff reported a close team which supported each other whilst on shift, recognising that they were working with a challenging patient group

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing persons employed by the service provider in the provision of a regulated activity must: (A) receive such appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they are employed to perform. we found that every shift did not have suitably trained staff to Intermediate life support (ILS) standard, as per policy

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment (1) Care and treatment must be provided in a safe way for service users without limiting paragraph(1) the things which a registered person must do to comply with that paragraph include (g) The proper and safe management of medicines. we found that controlled drugs were not being checked at every handover by two suitably qualified staff. we found that the controlled drug keys were being stored on the same key bunch as the main drug keys.