Healthcare at Home Ltd

Healthcare at Home - Head Office

Inspection report

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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 from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Healthcare at Home was established in 1992 and is operated by Healthcare at Home Limited. The service provides clinical homecare and the supply of essential medicines to patients throughout the UK. Patients' medicines and care funded by either the NHS, pharmaceutical companies or privately, and are dependent on a referral from a GP, hospital consultant or private health insurer.

Between 26 November and 14 December 2020, we carried out an unannounced, focused inspection of Healthcare at Home. The inspection was carried out in response to concerns raised about patients not receiving their prescribed medicines deliveries on time and being unable to contact the provider. Due to the seriousness of the concerns identified during the inspection, we suspended Healthcare at Home's rating and issued a Notice of Decision to urgently impose conditions on the provider's registration.

The conditions required the provider to:

- Ensure all service users who have had a failed delivery of any kind from 1 October 2020 to be reviewed by a suitably qualified professional to ensure that service users have not come to any level of harm.
- Devise and implement a system to ensure that backlogs of medicine deliveries were effectively mitigated against.
- Provide an action plan to the CQC outlining how the registered person intends to make improvements to the areas identified in the Notice of Decision.
- Provide a fortnightly report to the CQC which includes an analysis of audits undertaken to monitor completion and/or implementation of the systems set out in the above conditions.

The inspection rated Healthcare at Home inadequate and placed it into special measures. We told the provider it must take action to bring services into line with four legal requirements, Regulations 12, 16, 17 and 18 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

You can read our findings from our all of our previous inspections by selecting the 'all reports' link for Healthcare at Home on our website at www.cqc.org.uk.

This inspection was unannounced and focused to see what improvements the provider had made. We looked at the safe, responsive and well-led domains and focused on the concerns we raised to the provider following our previous inspection.

Our rating of this service improved. We no longer rated one or more key questions as inadequate and have removed it from special measures.

We rated the service as good overall because:

- The providers governance processes now operated effectively throughout the service. The provider had developed, implemented and monitored a service recovery action plan that demonstrated improvement.
- The provider had learned lessons from the implementation of a new information technology system in October 2020. The provider continued to develop its information technology systems for patients and staff, but with greater oversight and structures to manage risks.

Summary of findings

- The provider ensured all patients who had a failed medicine delivery, and did not receive the care they should, were reviewed by a suitably qualified clinical professional to ensure they had not come to any level of harm. Where harm was identified, the provider took immediate actions to refer the patient to back their identified responsible clinician for further review.
- The provider had improved performance to respond to and investigate complaints in a timely manner. Staff used concerns and complaints as an opportunity to learn and drive improvement.
- The provider had devised and implemented a system to ensure medicine deliveries were well managed to prevent backlogs. We saw improvement in the number of successful medicine deliveries made to patients on the day.
- The provider now ensured there was enough staff across all its services to ensure patients' needs are met. This included nurses, call handlers and dispensary staff. Managers regularly reviewed and adjusted staffing levels and skill mix and gave temporary staff a full induction.
- The provider had taken action to ensure the leadership and culture of the service encouraged staff and patients to raise concerns without fear of retribution. Staff and patients, we spoke with knew how to speak up or raise a concern and felt confident to do so.

However:

- The provider did not thoroughly investigate all incidents reported in the service. We remained concerned that incidents or near misses identified as resulting in no patient harm were not fully investigated.
- Although the provider monitored the practice of staff to check and record patient's allergy status immediately prior to every medicine administration. We continued to see the location of patient allergy information and staff's recording of allergy checks varied between the patient records we looked at.
- It remained difficult to identify vulnerable patients on the providers electronic record. This information was not immediately highlighted to staff accessing the patient's electronic record.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Good 	The main service provided by this provider was community healthcare services for adults. Our findings also apply to the core service community healthcare services for children, young people and families, as such we do not repeat the information but cross-refer.

Summary of findings

Contents

Summary of this inspection

Background to Healthcare at Home - Head Office

Healthcare at Home was established in 1992 and is operated by Healthcare at Home Limited. The service provides clinical homecare and the supply of essential medicines to approximately 206,000 patients throughout the United Kingdom. Patients' medicines and care are funded by either the NHS, pharmaceutical companies or privately, and are dependent on a referral from a GP, hospital consultant or private health insurer.

Clinical homecare describes care and treatment that takes place in a person's own home, including nurse administration of medicines. It minimises the need for patients to attend hospital as either an inpatient or outpatient and helps support early discharge from hospital for patients with complex care needs. Healthcare at Home also provides a supply and delivery service to patients who administer their own medicines at home, delivering approximately 110,000 prescriptions each month. Medicines supplied are for patients with a variety of conditions including; chronic diseases, cancer care, HIV medicines, medicines for haemophilia patients and rheumatoid arthritis.

In July 2021, Healthcare at Home Ltd rebranded to be called Sciensus. However, at the time of our inspection the service continued to be registered as Healthcare at Home Ltd.

Healthcare at Home is registered to provide the following regulated activities:

- Treatment disease disorder and injury.
- Transport services, triage and medical advice provided remotely.
- Management of supply of blood and blood derived products.
- Diagnostic and screening procedures.
- Nursing care.

The provider has a nominated individual and ten registered managers.

What people who use the service say

We spoke with eight people in receipt of a service from Healthcare at Home. Five people told us staff had provided information about how to raise a concern or complaint and the others believed they could easily find that information on the provider's website. All those we spoke with felt they could confidently raise a complaint, and without fear of a negative impact to the service they received. All spoke positively about the service provided by Healthcare at Home, reporting good or excellent service.

How we carried out this inspection

This inspection was unannounced and focused to see what improvements the provider had made. We looked at the safe, responsive and well-led domains and focused on the concerns we raised to the provider following our previous inspection.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure all incidents reported in the service are thoroughly investigated. Regulation 12(2)(b).
- The provider must ensure the location of patients' allergy status and staff allergy checks prior to medicines administration in consistent throughout all electronic patient records. Regulation 12(2)(b).
- The provider must have a system within its electronic patient record that immediately identifies vulnerable patients to staff. Regulation 12(2)(b).

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Not inspected	Not inspected	Good	Good	Good
Overall	Requires Improvement	Not inspected	Not inspected	Good	Good	Good

Good

Community health services for adults

Safe	Requires Improvement
Responsive	Good
Well-led	Good

Are Community health services for adults safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Staffing

The service now had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The provider now had enough nursing staff to safely meet the needs of patients and administer essential medicines in patients' homes. Clinical and scheduling staff met regularly to review activity and demand for the service. They planned staffing and ensured there was enough staff with the right skills to meet the needs of patients using the service. Managers met daily to review current and future staffing. This included responding to staff sickness and ensuring all scheduled patients had an allocated appointment. Senior staff met and discussed staffing at clinical governance meetings. Staff we spoke with told us there was enough staff to meet the needs of patients.

Between April and June 2021, the provider recorded 202 medicine incidents occurring because of a lack of nursing resource. This accounted for 0.4% of the providers clinical activity during this period and only one incident recorded patient harm. This was lower than at our previous inspection when, between July and October 2020, the provider identified 807 medicine incidents occurred because of a lack of nursing resource.

Clinical managers completed staff rosters for their nursing team. The provider required staff to give six weeks' notice of planned leave and limited the number of staff within a team that could take leave at the same time. Clinical managers shared completed rosters with scheduling staff.

The provider had procedures in place to manage staff sickness notified at short notice. This included flexible staffing arrangements and staff movements from neighbouring regions. Scheduling staff only cancelled and rearranged patient appointments as a last resort. Staff reported cancelled appointments as incidents and kept records to ensure a patient's appointment wasn't cancelled or rearranged again.

The provider worked closely with purchasers of its clinical services to manage referrals and demand for that service. For example, clinical and scheduling staff met daily to discuss referrals into services.

When needed, the provider used agency nurses to maintain safe staffing levels. The provider interviewed agency staff to ensure they had the right skills and experience to meet patients' needs. Agency staff received the same induction, training and supervision as the provider's own staff.

The provider had initiatives to support staff recruitment. Managers used a vacancy tracker tool to support recruitment and plan staff. The tracker helped managers identify and plan for shortfalls in service provision where vacancies existed or were expected.

The provider had enough staff in other areas of the service including call handlers. Following our previous inspection, the provider trained call handlers to manage inbound and outbound calls. This enabled staff to be moved between inbound and outbound calls as demand dictated. Call handlers we spoke with told us there was enough staff in their teams.

Mandatory Training

The service provided mandatory training in key skills to all clinical staff and made sure staff completed it.

The provider monitored the completion of mandatory training by all staff. At the time of our inspection, the provider reported staff completion of most mandatory training in excess of 90%.

Quality of records

Records were not always clear, and information was not always easily accessible to staff providing care.

We found it remained difficult to identify vulnerable patients on the provider's electronic record. For example; we saw no system to 'flag' those patients. Staff recorded vulnerabilities specific to a patient in the important information area of the patients' electronic record. Staff we spoke with knew where to find information specific to a vulnerable patient, including safeguard and cardiopulmonary resuscitation. However, it remained that this information was not immediately highlighted or easily searchable to staff accessing the patient's electronic record. This meant staff supporting patients were not always immediately aware of any vulnerabilities and the provider was unable to search for, and find, vulnerable patients who may need additional support in the event of specific incidents.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

During our previous inspection, we found the provider's dispensing sites were unable to meet all demands for medicines. In October 2020, the provider recorded that only 87% of all medicine deliveries to patients were delivered on the day. We told the provider they must devise and implement a system to ensure backlogs of medicine deliveries were effectively mitigated against.

The provider had increased dispensary staffing by the equivalent of 38 full time employees and reviewed their standard operating procedures for managing capacity in customer patient services and order reconciliation. The dispensary operations manager completed daily monitoring of all patient orders that passed through dispensary to ensure they were fulfilled and passed to dispatch. Information from the provider showed that between January and June 2021, 98% to 99% of all medicines deliveries to patients were delivered on the day. Of those medicines not delivered on the day, 98% to 99% were delivered to patients within five working days.

Good

Community health services for adults

In October 2020 following the installation of the provider's new information technology system, systematic issues with the electronic patient records system meant 9,885 patients did not receive their medicine delivery on time. Following our previous inspection, we told the provider they must ensure all patients with a failed delivery who did not receive the care they should have done, were reviewed by a suitably qualified clinical professional to ensure patients had not come to any level of harm. Where harm was identified, the provider took immediate actions to refer the patient to back their identified responsible clinician for further review. We saw staff made attempts to contact all 9,985 patients to establish if they had experienced a missed or delayed medicine dose as a result of a failed delivery. In total 5,434 patients responded, of which 4,747 reported no missed or delayed medicine dose. The provider completed at total of 1,154 clinical reviews with patients to ensure they had not come to any level of harm. For patients that hadn't responded to the provider's contact attempts, staff referred patients to their NHS trust for further review. We saw the provider continued to monitor and clinically review patients who reported a missed or delayed medicine dose as a result of a failed delivery.

We told the provider they must ensure staff record and check patient's allergy status prior to every medicine administration. The provider had updated processes and delivered training for staff to check and record patient's allergy status in a case study presentation, clinical safety alerts and additional clinical documentation training. We saw the provider's clinical record checking standard operating procedure guided all staff to check patient's allergy status prior to any scheduled visit or telephone call and repeat this with the patient during the appointment. Clinical staff told us they knew where to find allergy information in patient's records and checked allergy status with patients before administering medicine to patients.

The provider audited clinical records to ensure staff checked and recorded patient's allergy status. Audits completed between January and May 2021 demonstrated 98% to 99% compliance. However, in our checks of clinical records we found the patient's allergy status was only clearly recorded in six of the eight records we reviewed. We also found the location of patient allergy information and the location of allergy checks completed by staff varied.

The provider had developed a new electronic clinical record. The new clinical record was being tested ahead of being made available to all staff. We saw the new record highlighted patient's allergy status and included prompts for staff to check and record patient's allergy status prior to and during appointments.

Staff continued to work with patients to better manage their medicine supplies. Where possible, the provider promoted a buffer stock of medicine for patients. However, not all prescribing NHS trusts supported this. Staff checked buffer stock with patients and the provider had delivered additional training to staff specific to managing buffer stock with patients. We saw clinical governance discussion included the monitoring and uptake of patients' buffer stock.

Incidents

The provider did not investigate all incidents reported in the service. However, staff recognised and reported incidents when they occurred, and the provider shared lessons learned with staff from the investigations they completed.

At our previous inspection we identified the provider must investigate all reported incidents and establish what, if any, level of harm has occurred. We were not assured that the providers existing actions to triage all incidents, and then monitor for adverse trends in incidents of no patient harm or near misses completely fulfilled the requirements of this regulatory breach.

Good

Community health services for adults

Staff we spoke with knew what incidents to report and how to report them. Staff told us patient contacts often generated reportable incidents including; missed medicine doses, hospital admissions and complaints. Staff also reported positive patient outcomes as incidents. For example; feeling well or symptom reduction.

Staff generated electronic incident reports directly to the patient safety team. Members of staff from the patient safety and pharmacovigilance teams reviewed all reported incidents to determine if a patient had been harmed as a result of the incident. The provider ensured staff in these teams had specialist training to complete this task.

The provider required all incidents that identified patient harm to be fully investigated. Staff in the patient safety and pharmacovigilance teams escalated these incidents within the service for further action and departmental investigation. In addition to incidents that led to patient harm, the provider required all dispensary errors and nurse practice errors to be fully investigated including if they had resulted in no identified patient harm. Dispensary errors and nurse practice errors included medication errors, infection control incidents and alleged patient abuse. Between January and June 2021, the provider identified 156 nurse practice errors and 97 dispensary errors.

We looked at five patient records with one or more incidents reported. We saw evidence of actions taken to manage the incident and a record identifying if patient harm had occurred.

Between January and June 2021, the provider recorded 933 incidents of low patient harm and two of moderate patient harm. We reviewed root cause analysis investigation reports for both incidents identified with moderate patient harm. One was a dispensary error and the other a customer and patient services error. The provider offered the patient an apology in both incidents. We saw both identified learning and preventative actions for the service including; staff training, reflective practice and updates of standard operating procedures.

The provider monitored incidents where no patient harm was identified and made a full investigation when any adverse trend was seen. Senior staff met to discuss identified adverse trends at clinical governance meetings. For example, in July 2020 the provider identified increased loading dose medicine incidents and completed a root cause analysis investigation. We saw the provider shared learning from this investigation with staff and monitored for further incidents. The provider monitored and responded to near miss incidents in the same way. We remained concerned that incidents or near misses identified as resulting in no patient harm were not always fully investigated. For example, in incident records we reviewed where a patient reported a failed delivery, the provider did not evidence the specific corrective actions taken and how they would mitigate the risk of a further failed delivery. This meant for some patients, they had to raise multiple incidents where deliveries had continued to fail.

Since our previous inspection, the provider had introduced patient safety improvement groups. The purpose of the groups was to monitor patient's safety incidents and share learning outcomes. The provider shared records from the meetings of both the clinical and logistics patient safety improvement groups. We saw that staff discussed incidents with identified patient harm, incident trends in all areas of the service and a record of open incident investigations. Staff shared outcomes from patient safety improvement groups at clinical governance meetings.

Staff told us they received feedback from the investigation of incidents. This happened during supervisions, local team meetings and service wide team meetings. Staff from clinical and logistic services provided examples of feedback from incident investigations in their local teams. We also saw examples of feedback and learning shared across the service.

Are Community health services for adults responsive?

Good

Community health services for adults

Good

Our rating of responsive improved. We rated it as good.

Access to the right care at the right time.

People could access the service when they needed it and received the right care in a timely way.

The provider's patient services team operated between 8am and 8pm Monday to Friday and between 8am and 4.30pm at weekends and bank holidays. There was also an electronic live chat platform through which patients could make contact. For patients in receipt of oncology and early supported discharge services, the provider operated a care bureau. The care bureau was staffed with nurses and operated 24 hours daily.

Since our previous inspection, the provider had improved the proportion of answered calls to the service. Between January and June 2021, staff consistently answered in excess of 80% of all calls to the service. This had improved from 55% reported at our previous inspection and met the provider's target. We also saw since February 2021, the average time for staff to answer a call had been within the provider's target of five minutes. This had improved from an average call answered time of 11 minutes in December 2020. Patients we spoke with told us they found the service easy to contact either by telephone or by live chat.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

We spoke with eight patients in receipt of a service from Healthcare at Home. Five told us staff had provided information about how to raise a concern or complaint and the others believed they could easily find that information on the provider's website. The provider's website had information for patients about how to contact the service, including how to raise a concern or compliant.

The provider had policies and procedures in place to guide staff when handling complaints.

Formal complaints to the provider had decreased since our previous inspection. Between January and June 2021, the provider recorded monthly receipt of between 337 and 402 formal complaints. This had reduced from October to December 2020, when the provider recorded monthly receipt of between 551 and 754 formal complaints.

Complaints to CQC from patients reporting a missed or failed medicine delivery had decreased from 32 complaints received in October and November 2020. Between April and June 2021, CQC received six complaints. Common themes within these complaints included multiple failed deliveries and poor communication from the provider.

The provider was responsive to patient complaints shared and escalated to them by CQC. This included acting to immediately resolve a complaint and providing information on the root cause to a complaint. For example, identifying where a hospital delay issuing a prescription caused the provider to miss a medicines delivery.

Good

Community health services for adults

The provider had improved the time it took staff to investigate and close formal complaints. At our previous inspection, the provider recorded an average of 23 days to investigate and close formal complaints. Between January and June 2021, staff took an average of six and a half days to investigate and close formal complaints. This was below the provider's target of 20 days.

Since our previous inspection, the provider had reviewed their complaints processes and the structure of their patient services and experience team. The provider had made changes which allowed members of the patient services and experience team greater flexibility to respond to and manage periods of increased complaints volume to the service.

The provider used concerns and complaints as an opportunity to learn and drive improvement. Staff investigated and recorded the reason for the complaint. For example, a communication breakdown with the patient or a lack of staffing capacity. Senior staff met to discuss complaint themes and trends at monthly clinical governance meetings. Senior staff shared outcomes and learning from serious complaints during a monthly meeting with all staff in the service.

Are Community health services for adults well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders were visible and approachable in the service.

Staff we spoke with told us that leaders in all areas of the service were now visible and approachable. The chief executive officer presented at staff inductions and chaired monthly virtual team updates to all staff in the organisation.

Staff told us leaders shared information about the service effectively, this included information about improvements and challenges in the service. Staff had access to service updates, policy and procedure guidance, staff assistance and wellbeing resources through the providers intranet pages.

Culture

Staff felt respected, supported and valued. The service now had an open culture where patients and staff could raise concerns without fear.

Senior staff encouraged, openness and honesty at all levels of the organisation. The chief executive hosted a question and answer session as part of monthly updates to all staff. Staff had the opportunity to raise questions anonymously if they wished. Office based senior staff shared communal desk spaces with staff in their team. The provider encouraged staff to raise concerns with managers during one to one and team meetings.

Staff knew how to speak up or raise a concern in the service and felt confident to do so. Since our previous inspection, the provider had updated and relaunched their Safe to Speak Out training with staff. At the time of the inspection, the provider recorded 94% of staff had completed this training. Staff could raise concerns anonymously to the provider's external whistleblowing service. We saw the provider publicised this service online and in the monthly staff magazine.

Good

Community health services for adults

Patients we spoke with believed they could complain or raise a concern to the provider without any negative impact to the service they received.

Between January and June 2021, the provider reported receipt of two whistleblowing concerns. Since April 2021, CQC received two whistleblower concerns from Healthcare at Home staff. One concern alleged the provider did not have an open and honest culture and feedback from staff was not listened to.

The provider had a range of initiatives in place to support staff health and wellbeing. This included mental health first aiders, a staff forum, staff recognition awards and wellbeing surveys during the COVID-19 pandemic.

Staff told us they felt supported, respected and valued. Staff gave examples of long service awards and thank you emails from senior leaders during the COVID-19 pandemic.

Governance

The provider had embedded governance, oversight and assurance systems to identify, reduce and manage risks to the service.

In October 2020. the provider introduced a new information technology system across its service which had resulted in avoidable harm to some patients. The provider demonstrated its action plan to recover services had been successful. As part of the conditions we imposed on the provider's registration following our previous inspection, the provider submitted fortnightly reports to CQC. The reports detailed performance in the areas of medicine deliveries, customer services, complaints and patient safety incidents. Fortnightly reports demonstrated that since December 2020, performance quickly returned to, and was maintained at, the provider's target levels.

Since our previous inspection, we saw the provider had developed its clinical governance structure to introduce patient safety improvement groups. Senior staff met monthly at clinical governance meetings. Records showed varied attendance which included clinical staff and logistics staff with oversight of medicine dispense and delivery services. Meetings followed an agenda with standing agenda items including; audits, patient safety reports and clinical complaints. Staff told us risk register discussions were to be added as a standing agenda item in clinical governance meetings.

The provider had guidance for staff and systems in place to manage work orders identified as high priority. Work orders identified as high priority included all patients with a previous failed medicines delivery, all patients with a rescheduled appointment and all patients who reported a missed medicines dose. Staff in customer and patient services worked with patients to ensure completion of high priority work orders. Senior staff in customer and patient services, dispensary and warehouse departments monitored high priority order processing daily. The provider understood risks of missed deliveries increased risks of missed medicine doses for patients.

The provider had a board assurance framework with a purpose to ensure the service had a clear organisational and governance structure necessary to support the service's business model, size and complexity. The framework detailed responsibilities and purpose of groups in the clinical governance structure. We saw some groups included external oversight to provide scrutiny and challenge of the group's actions.

Information Management

Good

Community health services for adults

The service collected reliable data and analysed it. Staff could find the data they needed in easily accessible formats to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

The provider had improved its data collection and analysis systems, and this was demonstrated in the providers fortnightly reports to CQC. Senior staff told us the adverse events of October 2020 had driven improvements to data collection and analysis to give better visibility of performance in the service.

As part of a business transformation programme, the provider planned further changes to its information technology systems for patients and staff. The provider's planning demonstrated it had learned lessons from its October 2020 rollout to identify and manage associated risks. Where the October 2020 rollout had introduced immediate changes throughout the service, the new plan introduced changes in managed phases to small numbers of patients and in specific areas of the service. Existing systems would be maintained and run alongside changes made. The provider had the ability to slow down, pause and roll back the change process. We saw this demonstrated as the provider delayed initial phases of rollout to ensure patients and staff were ready.

The provider's notifications to CQC were in line with the requirements of the Care Quality Commission (Registration) Regulations 2009 (Part 4). Our previous inspection identified the provider did not always follow their policy to notify CQC of serious incidents. We saw the provider had updated their serious incident policy and now only incidents of serious patient harm should be notified. Since April 2021, the provider identified no incidents that required notification to us.

We continued to meet monthly with the provider, during which they kept us updated with service developments and issues with a potential to disrupt the service delivery. For example; seasonal impacts and staff recruitment and retention.

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
Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not thoroughly investigate all incidents reported in the service. It was difficult to identify vulnerable patients on the providers electronic record. This information was not immediately highlighted to staff accessing the patient's electronic record. Patient's allergy status was not clear in all the records we looked at. The location of patient allergy information and the location of allergy checks completed by staff varied.