Barchester Healthcare Homes Limited

Hugh Myddleton House

Inspection Report

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Summary of findings

Overall summary

Hugh Myddleton House provides accommodation for up to 48 people who require nursing, personal care and support. At the time of our inspection 46 people were using the service.

People who used the service and their relatives were happy with the service received. Staff treated people kindly and with compassion. Staff were aware of people's likes, interests and preferences. However, we were not able to find evidence that staff understood people's care and support needs in all cases. The relatives we spoke with told us staff kept them informed of people's progress and any changes in their health care needs.

Ten people who used the service told us that they felt safe. Staff were knowledgeable in recognising signs of potential abuse and concerns were appropriately reported. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards.

Risk assessments and care plans were in place, however, we found that many of them lacked detail and there were some inaccuracies in the information recorded in people's care records. This meant we could not be assured that care was always tailored to people's individual needs and that preventative measures were put in place to protect people's welfare and safety.

The home did not meet requirements around the storage, safe administration and appropriate recording of medicines. This put people who used the service at risk of not receiving medicines safely.

People who used the service were offered a range of activities to suit their needs. They told us they enjoyed some of the activities offered, and told us that they were able to decide if they wanted to take part in activities or not.

The manager had been in post for six weeks and staff told us that, so far, they felt supported by her. Staff did not receive regular supervisions and appraisals which meant that staff were not being supported to deliver care safely and appropriately. The manager had not submitted an application to the Care Quality Commission to become the service's registered manager; however we were told that she had started the process.

There were three breaches of health and social care regulations. You can see what action we told the provider to take at the back of the full version of the report. We considered the issues related to medicines management were serious enough to take enforcement action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Staff were knowledgeable in recognising signs of potential abuse and the reporting procedures to the local authority. Risk assessments were undertaken to establish any risks present for people who used the service, however, we found that management plans were not always put in place to minimise these risks. We also found that prevention plans were not always available, for example, to monitor that people were hydrated or regularly repositioned when they were at risk of pressure ulcers.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager and staff were knowledgeable about DoLS. We saw in the past staff had followed relevant application processes and the conditions made by a supervisory body. Relevant staff -were trained to understand when an application should be made, and in how to submit one.

We found that the provider failed to protect service users against the risks associated with unsafe use and management of medicines, because appropriate arrangements for the recording, safe administration, safe keeping, using and disposal of medicines were not in place.

Are services effective?

Assessments were undertaken to identify people's needs and these were used to develop care plans for people who used the service. We heard that changes in people's health were monitored and reported, when appropriate, to family members. However, we found that some people's care records were inaccurate and did not contain sufficient detail. This meant people were at risk of not receiving care in line with their needs.

People were provided with a choice of food and drink at mealtimes and throughout the day. However, we found that people who were at risk of dehydration or malnutrition did not always have their food and fluid intake accurately recorded.

Staff were skilled and experienced, and received the training they required to meet people's needs. However, training records viewed showed that only 78% of staff employed at Hugh Myddleton House currently had up to date training. The manager told us that the reason for this was due to the departure of a number of staff and new staff had started who had not yet completed the mandatory training provided.

Summary of findings

Are services caring?

We observed staff interacting with people who used the service and they treated them kindly and with compassion. Staff demonstrated to be knowledgeable of people's needs and their likes, interests and preferences. Staff were conscious of the need to maintain a person's privacy. However, we were advised by one person who used the service, that at times people were not always treated with dignity and staff were not knowledgeable about people's interests and wishes. We informed the local authority of this in line with the Pan London Multi Agency Safeguarding procedure.

Staff ensured that people's dignity and privacy was respected, support provided ensured people's independence was maintained, for example, doors were closed when personal care was given and people were encouraged to eat independently if they were able to do so.

People were listened to and there were systems to obtain people's views on their care and the way the service was delivered.

Are services responsive to people's needs?

A person's capacity was assessed to establish whether they were able to make decisions about their care. For example, we saw that some people's records stated they could make day to day decisions about food and clothing, but were unable to make decisions about their care and treatment. We also viewed Do not Attempt to Resuscitate (DNAR) forms, which had been fully completed and showed that people who used the service or their relative had been involved in the decision. We observed activity coordinators on duty, they demonstrated extensive knowledge of people who used the service and provided wide range of activities for groups and individuals.

People felt able to raise concerns and make complaints and had confidence that these would be dealt with appropriately. People told us about concerns they had raised with the manager previously and said they had been addressed.

Are services well-led?

The home had a newly appointed experienced and qualified manager who told us that she promoted high standards of care and support, This was evident through discussions with staff and the deputy manager who told us that the manager had begun to make positive changes to the care provided. Staff told us they felt well supported by the manager so far and senior staff and "they understood their roles and responsibilities."

Summary of findings

There were processes in place to review any incidents and complaints, and these were appropriately investigated and learnt from. Systems were in place to monitor the quality of the service and action plans were put in place to address any concerns identified.

While we observed staff to be available in sufficient numbers, we also saw staff to be very busy and some comments by people who used the service indicated that at times not enough staff were available. The manager had started to review the staffing levels at the home, and forwarded a business case to their line manger requesting additional staffing in particular during busy periods.

Summary of findings

What people who use the service and those that matter to them say

We looked a satisfaction survey carried out in 2012 and a survey carried out by an external company from 2013. Survey returns about the treatment and care provided were mostly positive. We saw an action plan dated February 2014, drawn up as a result of these surveys and we spoke to the manager about the action plan. The manager advised us that she had begun to implement the issues highlighted in the action plan.

People who used the service and their relatives were mostly happy with the service they received. They told us they felt safe, although some had concerns around insufficient staff availability at times. One comment made by a person included, “staff is good, but sometimes at busy periods it looks like there are not enough help”. Another comment made by a relative, “my father is always well dressed, they look after him very well” or “carers know what they are doing, my mother is happy here.”

People who used the service spoke positively about staff, comments included, “when the ‘three stooges’ are on duty all runs particularly well” or “it’s a nice place.”

Hugh Myddleton House

Detailed findings

Background to this inspection

Before our inspection we reviewed information we held about the home including the last inspection report from September 2013. We visited the home on 02 May 2014 and 06 May 2014. The inspection team consisted of an inspector, an expert by experience who had experience of services for people with dementia and a professional advisor, who in her full time employment was a pharmacy advisor. We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

We spent time talking with people living in the home, their relatives, visitors, the manager, nurses and care staff. We observed care in the dining room at lunchtime and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to speak with us. We looked at all communal parts of the home and some people's bedrooms, with their agreement. We also looked at five care records and records relating to the management of the home. We asked the provider to complete a 'Provider Information Return', but we did not receive the document in time for this report.

We spoke with 11 people living in the home, three relatives and visitors, five care workers and nurses, the home's manager and one visiting social care professional.

Are services safe?

Our findings

Ten people told us they felt well cared for and safe in the home. Their comments included: "yes, I feel very safe here;" "I do feel safe here," and, "I am confident that dad is safe here". People and their relatives also told us staff usually responded to requests for care and support promptly. People who used the service told us that there was usually a quick response to call bells. However, one person said, "The response for calls for help at weekends and night time is not that quick and I sometimes have to wait for a long time to get help." The manager was in the process of auditing the call bell response by staff, but at the time of our visit had not completed it.

Staff spoken with demonstrated good understanding of how to report safeguarding concerns and told us that they were confident that senior management would deal appropriately with allegations or concerns. One care worker told us that they would contact the operations manager or the CQC if they felt that issues were not dealt with locally. The home had a safeguarding adults procedure available, which could also been accessed electronically through the provider's website. Staff told us that they had received safeguarding training; however, the manager undertook a training audit on 27 February 2014, which showed that 19 staff required training in this area. We discussed this with the manager who told us that all staff had received a letter reminding them to complete their online training.

The service was not always identifying or managing risks appropriately. We viewed accident and incident records. The records were detailed, however there was little evidence that actions were taken to reduce the risk of similar accidents or incidents happening again. The manager undertook an accident and incident audit in April 2014.

We observed staff responding to behaviours presented by people who used the service and found staff demonstrated good understanding of how to respond pro-actively, by diverting people's attention or offering alternatives. For example, we observed a person becoming anxious. Staff knew how to offer support and settled the person down. We saw from training records that eight staff attended non-abusive psychological and physical intervention (NAPPI) training on 24 April 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider was meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, appropriate policies and procedures were in place for staff to refer to. Staff received training to understand when an application should be made, and in how to submit one. The most recent training was attended by 12 staff on 4 March 2014.

We found inconsistencies in people's care records. In one example, a person was known to refuse their medication, but there was no risk management plan or strategy in place to address this. In another, a person's fall was recorded in one section of their file, but was not acknowledged in their risk assessment, so the increased risk was overlooked. In a third case, a person was assessed to have a low risk of choking despite a hospital admission for aspiration.

We found unsafe practice was taking place. People's medicines were not being managed so they were received safely. We looked at medicines records, medicine supplies and storage arrangements for five people living at the service. These records included medication administration records (MAR), and records of medicines received and disposed of.

On the first day of the inspection we found the ground floor medication room with the door open and without a member of nursing or care staff in attendance. The drug trolley had been left wide open with three people's medicines within easy reach of passers-by. The staff nurse explained that these medications were left over from the morning round and they had not yet had time to destroy them.

We found that the drug trollies were not secured whilst in the medication room. The first floor medicines' fridge was not lockable. An unlabelled box of Paracetamol was stored; it was not clear why or for whom it was prescribed.

The ground floor medication trolley did not store external products separately from internal medication, for example, fungal nail infection treatment was stored next to injections and oral medication. We checked the controlled drugs (CD) cupboard and saw evidence that staff reordered CDs without considering the balance in stock.

We inspected the medicines administration records (MAR) for five people who used the service and found discrepancies in all of them. In one case the person had a

Are services safe?

known allergy to common medicines and this was not recorded on the MAR chart. In another case, a medicine was only supposed to be administered if the person's pulse was within a particular range. There was no evidence that pulse checks had been carried out.

These factors amounted to a breach of the relevant legal regulation (Regulation 13). The action we have told the provider to take can be found at the back of this report.

Are services effective?

(for example, treatment is effective)

Our findings

We asked people who used the service and relatives if they had been involved and were able to contribute to their care plans. One relative told us that staff always informed them of changes in the person's care and asked them for their advice. One person told us that their daughter was involved with their care plan. We looked at this person's care plan and found evidence of the daughter being consulted about the person's medicines and care requirements.

The care plans we looked at included a pre-admission assessment of the person's health and social care needs, life history and hobbies and interests; this information had been used for the formulation of care plans. However, we found shortfalls in three of the five care records we viewed. People's changing needs were not documented in care plans, which put them at risk of their needs not being met.

Staff had no individual guidance to follow to reduce the risk of people becoming challenging and deal with such behaviours safely and appropriately. Staff told us that one particular persons presented challenging behaviour, however the persons care plan made no reference to such behaviour and lacked information in how to best respond to the person if the person becomes challenging.

In another person's care plan we read that the person was able to mobilise independently and was not at risk of developing pressure ulcers. When speaking to staff however we were told that this was not correct and the person required increased support in mobilising. The persons care plan also recorded that the person had a fall recently resulting in injuring himself. This however had not been documented in the body map, nor had the provider updated the person's falls risk assessment.

Another person's care plan documented that the person required support to manage their personal care. Staff however told us that the continence pads had been changed, which was not documented in the person's care plan.

The provider did not respond to peoples changing needs and provided the care people who used the service required. Another care plan recorded that a person required regular repositioning due to a grade 3 pressure ulcer, however we found no records to show that this had happened. This person's care record also stated that the person had been gaining weight, however monthly weight records demonstrated that the person's weight steadily declined.

The service was not effectively monitoring people's hydration. One of the care plans stated that the person required a minimum fluid intake of 1.15 litres each day. We looked at this person's fluid monitoring charts over a four day period and saw that their fluid intake had only been documented on one day. This was not in line with the provider's own nutrition and hydration policy, which stated, 'The care plan will include all necessary information to ensure that the individual receives an optimum level of hydration'.

We spoke to kitchen staff who told us that people's dietary needs were recorded in a folder in the kitchen, which we saw during our visit in the kitchen. We saw that people with low body mass index had been referred to a dietician and nutritional supplements had been prescribed to maintain and increase people's weight. People who required special prepared meals had been provided with these and we saw that food had been pureed individually and looked appetizing. We observed lunchtime at the dementia unit and were impressed how positively staff interacted with people who used the service and how much time staff took to support people to eat their meals. A comment made by one member of staff, "One person takes about 40 minutes to eat, but I don't mind if they need that I give them that time."

People who used the service were able to choose from the daily menu, which was displayed on each floor. There were two choices of starter and main course and people were encouraged and allowed time to make their own choices. The manager told us that she was currently in the process of reviewing the menu together with the head chef and people who used the service. Where needed, people had the use of adapted plates and cutlery. If people required assistance from staff to eat their meal this was done with respect, patience and good humour.

We had received information that staff did not receive regular supervision and appraisals; this did not give staff the chance to discuss concerns in private and resolve issues with the help of their manager. We looked at supervision and appraisal records for five staff and noted that staff were not provided regular supervisions and

Are services effective?

(for example, treatment is effective)

appraisals. This, together with the lack of regular staff meetings, did not provide adequate opportunities for staff to discuss issues relating to the care provided to improve the quality of care.

Are services caring?

Our findings

We observed staff to be kind and caring. They knew each person's likes, dislikes, and preferences. One relative told us, "I visit regularly and dad is always well dressed and his health has improved, I cannot fault the staff. There seems to be plenty of staff around and you only have to ask for something and they do it. They are all very kind people." We observed staff interacting with people and saw they were familiar with their needs and interests, and were keen to meet people's needs. We observed that staff had a good relationship with people who used the service and their relatives.

We observed lunch on the dementia unit where staff were supporting those that required it. They were patient and polite, and supported people at the pace set by the individual. People were given choice about what they liked to eat and whether they wanted dessert, tea, coffee etc. Staff knew people's behaviours and responded to these well. For example, one person who used their hands to eat was asked by staff to use the cutlery provided, staff explained that it was not very hygienic to use their hands. When people asked to use the bathroom, staff responded well by interacting and supporting people to use the toilet.

Staff were aware of the importance of maintaining a person's privacy. Staff told us they ensured people's privacy as much as possible whilst undertaking personal care and ensured only those required to support the person were present during that time. They also took care to ensure people were well presented and kept clean. One visitor told us the staff helped their relative to get changed if they spilt something down their top during meal times. Visitors told us their relatives were always clean, dressed well and had their hair brushed. One relative told us, "[my relative] always looks clean and well cared for, [they] would like that."

Staff treated people who used the service with dignity and respect. Throughout both days we saw staff treated people with patience and understanding and always spoke with them in a respectful way. Staff were able to tell us each person wanted to be addressed and how some people preferred staff to use Mr or Mrs while others preferred their first name to be used. We also saw staff respected the dignity of residents by knocking on doors before entering rooms and closing doors when supporting people with their personal care.

Whilst most people were positive when asked about the treatment and care provided, two people told us that, on occasions, they had to wait longer than expected for staff to answer call bells during busy times such as morning and lunch time. We discussed this with the manager, who told us that she was aware of this and had already put a business case forward to senior management to increase staffing levels during these times.

We observed a senior staff meeting during the second day of our inspection, staff told us that this was a regular meeting, during which the week ahead was discussed, any concerns in regards to people's needs were raised and organisational information was provided.

We noted that over the past year residents' meetings had failed to happen; the last residents' meeting was held on 21 January 2013. The manager told us that this was due to the change in management. However, since the new manager commenced employment in April 2014, she had arranged a residents' meeting for 8 May 2014. People who used the service told us that they were aware of this meeting and told us they wanted to discuss activities and the menu.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People living in the home told us they enjoyed the activities that were arranged. One person said, "it's not all for me, but there are some things I enjoy, I particularly look forward to scrabble." Another person said, "I'm often in the garden if the weather allows, it's lovely." Relatives we spoke with told us staff kept them informed about their relative's care and any significant events or changes. We saw people's care plan files included contact details of their next of kin, including whether or not they should be contacted in case of an emergency. We observed a meeting between the manager and a relative, during which information about a change in the person's healthcare needs was discussed. The manager suggested making a referral to a specialist healthcare professional.

During the day a group of people took part in a movement and music session and another group of people played scrabble. The people who took part enjoyed each of these activities. We also met visitors from the local church who told us they came to the home each week to talk with people and offer Holy Communion. A member of staff told us of a recent significant breakthrough in building a relationship with a person who used the service. We spoke to this person who told us how much they trusted a member of staff and felt able to talk to the member of staff about anything.

The manager told us that if people needed an assessment under the Mental Capacity Act 2005; this would be carried out; however we were also told by the manager that, currently none of the people who used the service had been assessed as lacking capacity. One of the care files we looked at included advanced care plans where staff had discussed end of life care wishes with people and their relatives. The manager told us that where possible, this was done with the person living in the home, but if they were unable to make decisions about their care, appropriate people were involved, for example their relatives and GP. Do Not Attempt Resuscitation (DNAR) forms in people's care files had been appropriately signed by the person living in the home or their relatives, as well as the GP and staff from the home. Where a relative had a power of attorney this was clearly recorded so staff knew who to contact about decisions relating to the person's care.

Relatives told us they had seen a copy of the provider's complaints procedure as it was included in a welcome pack given to their relative when they moved to the home. The people living in the home and the relatives we spoke with told us they had never needed to make a formal complaint. However, one person told us that they spoke to the manager because their room was very warm. The manager told us that room temperature could not be adjusted for each individual room, but she suggested opening the window to let some air in. Other people told us "I have nothing to complain about, but I would if I was unhappy and it would be to the manager" and "I would probably complain to the manager." A relative added, "the new manager seemed to listen to my suggestions." The manager told us most complaints were resolved by people's key worker and named nurse and did not proceed to the formal procedures. She confirmed there had been five formal complaints in the last twelve months; these complaints had been acknowledged and resolved in line with the provider's complaints procedure. We found that complaints had been responded to appropriately and actions were taken to reduce further complaints from happening in the future.

Are services well-led?

Our findings

We viewed two different satisfaction surveys, one survey was carried out in 2012, by Barchester Homes and the second survey, entitled 'Your Care Rating', was carried out in 2013 by an external market research company. Both surveys had tended towards the positive in regard to the care and treatment received at Hugh Myddleton House. A combined action plan had been implemented in February 2014, which highlighted three areas for improvement. We spoke to the manager about this action plan and she advised us that she had started work on the action plan; she was in the process of finalising a call bell audit, discussed hygiene with the domestic manager and looked at ways to provide activities staff during the weekends. This demonstrated that the home learned from feedback and strove to improve outcomes for people who used the service.

Meetings between nursing-, catering-, housekeeping staff and senior staff were arranged regularly and gave staff the opportunity to discuss service delivery. Staff told us, "it's an open forum" and they were all able to request items to be put on the agenda and discussed. We saw minutes of these meeting and observed a senior staff meeting, which showed that areas in relation to care and treatment had been discussed.

Overall, staff told us that the morale was good and our observation was that staff worked well together as a team. Staff told us that the new manager had been open so far. Senior management visited the home monthly to monitor and assess the quality of service provision; we viewed reports for the past four months. An infection control audit had been carried out on 29 April 2014, the audit highlighted that pedal operated bins were not working properly; during our visit on 2 May 2014 we witnessed a new delivery of pedal operated bins. This indicated that the quality of service was monitored and actions had been taken to improve the service.

We reviewed all complaints received by the home for the last twelve months. We saw that complaints had been investigated and responded to accordingly. If staff were mentioned in a complaint the manager undertook additional discussions to address the concerns identified. People who used the service and their family members were provided with feedback about the action taken in response to their complaints. We saw that feedback was provided to other health professionals if they raised any concerns and their feedback was sought to establish if they were satisfied with the improvements and action taken. Any clinical concerns and complaints were discussed during staff meetings, along with the progress of investigations. Information was disseminated amongst the staff team.

We viewed the staffing rota for the two weeks prior to our inspection. We saw that staff were allocated according to the differing needs of people who used the service. Some people told us that there were sufficient staff available, whilst others said staffing was not sufficient, in particular around busy times. The manager told us that she had been made aware of this and was currently in the process of reviewing staffing levels. Since starting work at Hugh Myddleton House the manager introduced a system of allocating a team leader during each shift for each floor. We observed interactions during lunch time and saw people working well together; the team leader allocated staff to work with people according to their individual needs. .

The new manager was a qualified registered nurse, who had numerous years of experience in managing nursing homes. She had instigated the registration process.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. The registered person did not take proper steps to ensure that each service user was protected against the risk of receiving care that was inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and to ensure their welfare and safety. Regulation 9(1)(b)(i-ii)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. The registered person did not take proper steps to ensure that each service user was protected against the risk of receiving care that was inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and to ensure their welfare and safety. Regulation 9(1)(b)(i-ii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of service users. The registered person did not take proper steps to ensure that each service user was protected against the risk of receiving care that was inappropriate or unsafe,

This section is primarily information for the provider

Compliance actions

by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and to ensure their welfare and safety. Regulation 9(1)(b)(i-ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting Workers. The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate supervision and appraisal. Regulation 23(1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting Workers. The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate supervision and appraisal. Regulation 23(1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting Workers. The registered person did not have suitable arrangements in place in order to ensure that persons

This section is primarily information for the provider

Compliance actions

employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate supervision and appraisal. Regulation 23(1)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of medicines. The registered person failed to protect service users against the risks associated with unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, safe administration, safe keeping, using and disposal of medicines used for the purposes of the regulated activity. Regulation 13

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of medicines. The registered person failed to protect service users against the risks associated with unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, safe administration, safe keeping, using and disposal of medicines used for the purposes of the regulated activity. Regulation 13