Barchester Healthcare Homes Limited

The Dales

Inspection report

Draughton
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 18 February 2016 and was unannounced. At the last inspection on 3 December 2013 we found the service was meeting the regulations we inspected.

The Dales provides nursing and personal care up to 56 older people, some of whom may be living with dementia. On the day of the inspection there were 52 people living in the home. The home is located in the small village of Draughton, which is close to the town of Skipton. Accommodation is on two floors accessible by a passenger lift. There are secure and attractive gardens and car parking is available on site.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home had sufficient suitable staff to care for people safely and they were safely recruited. The environment of the home was safe for people and safety checks were regularly carried out.

Medicines were not consistently managed safely to protect people. This was a breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of the report.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date in areas such as infection control, health and safety, food hygiene and medicine handling and also in specialist areas of health care appropriate for the people being cared for.

Staff had received up to date training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and that they should approach people with the assumption of capacity. They understood what needed to happen to protect the best interests of people whose mental capacity was impaired and we saw evidence that this was taking place.

People's nutrition and hydration needs were met. People enjoyed the meals which were of a good quality. Clinical care needs were met in consultation with health care professionals and people were accompanied to appointments when needed.

People were treated with kindness and compassion. We saw staff treated people with dignity and respect. Staff had knowledge and understanding of people's needs and worked together well as a team.

People were supported to engage in daily activities they enjoyed and which were in line with their

preferences and interests. Staff were responsive to people's wishes and understood people's personal histories and social networks so that they could support them in the way they preferred. Care plans were kept up to date when needs changed, and people were encouraged to take part in their reviews and to give their views which were acted upon.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. People we spoke with told us that if they had concerns they were always addressed directly with the registered manager who responded quickly and with courtesy.

The service had an effective quality assurance system in place. The Dales was well managed, and staff were well supported in their role. The manager had a clear understanding of their role and they consulted appropriately with people who lived at the service and the people who mattered to them, staff and health care professionals to identify any required improvements and to put these in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not always protected by the way staff managed their medicines.

People were protected from the risks of acquiring infection because the service had good infection control policies and procedure and staff acted on these.

Risks to people's safety were assessed and acted on and risk plans included how to maximise freedom.

People were protected by having sufficient staff who were safely recruited and had the skills and experience to offer appropriate care.

Is the service effective?

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed and where necessary, decisions were made in their best interests

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate. They involved people in decisions about their care.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests which supported staff to offer person centred care.

People were supported to live their lives in the way they chose.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon.

The Dales

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 February 2016 and was unannounced. The inspection was carried out by one inspector, a specialist advisor in nursing and an expert by experience.

Before the inspection we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we looked around the premises, spent time with people in their rooms and in communal areas. We looked at records which related to people's individual care. We also examined three staff recruitment records, the staff rota, notifications of events and records of meetings held at the home.

We spoke with three people who lived at the service, a visitor, the registered manager, a visiting health care professional, a visiting social care professional and three members of staff.

Requires Improvement

Is the service safe?

Our findings

Medicines were stored safely. Controlled drugs were stored separately and administered according to policy and procedure. Some prescription drugs were controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Medicines were supplied to the home in a Monitored Dosage System (MDS). MDS is a medication storage device designed to simplify the administration of solid oral dose medication. We found appropriate arrangements were in place for the ordering and disposal of all medicines. We observed a member of staff while they were dispensing medicines. They did so safely and according to policy and procedure. This ensured that the correct medicine was administered and signed for at the right time.

The registered manager told us they made regular checks on stocks and recording to ensure people received their medicines safely and at the time they needed them. We saw the results of these medicines audits. These had highlighted areas for improvement with action points in place and a timescale for completion. The required improvements had not been actioned in relation to some areas. For example, there were records related to the covert use of medicines. (These are medicines which are administered in a disguised form, for example in food or drink, without the knowledge or consent of the person receiving them. Covert medicines must never be given to a person who is capable of consenting to medical treatment.) These records did not always evidence the involvement of all required parties when it would be appropriate to gain their agreement. This was to ensure that such action was carried out in the person's best interests when they lacked the mental capacity to make a decision about taking certain medicines. Nursing staff described attempting to administer medicines orally with the residents' consent before resorting to covert administration, although the use of covert administration was not differentiated within the records. This meant people were not protected regarding covert medicines.

Care plan records detailing current prescribed medicines had not been reviewed in one case for the past two years. This did not reflect the medicines currently prescribed for a person. This meant there was a risk the person would not receive the medicines which had been prescribed for them. However, the risk was reduced because currently prescribed medicines were recorded on the Medicines Administration Record (MAR).

PRN medicines, which are medicines which are to be taken as needed, were not always accurately recorded on the MAR. We noted some gaps in the recording of medicines administered on the MARs with no explanation as to why these may not have been given written on the record. The lack of fully accurate recording meant that people were not always fully protected, as it was not clear if some medicines had been administered as prescribed.

Failing to ensure that people are protected through safe medicines management is a breach of Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they received regular medicine training updates and records confirmed this. This meant that people benefitted from being cared for by staff who were trained in best practice around medicine handling.

People appeared content and relaxed at the service. One member of staff told us, "People are as safe as they can be. There is sufficient staff to carry out care tasks but it would be helpful to have more staff so there was more time to spend with people."

We saw there were safeguarding policies and procedures in place. Staff had received safeguarding of adults and abuse awareness training which was kept up to date. Staff were clear about how to recognise and report any suspicion of abuse. They could correctly tell us who they would approach if they suspected there was the risk of abuse or that abuse had taken place. They understood who would investigate a safeguarding issue and what the home procedure was in relation to safeguarding. A safeguarding risk support tool was in place which included guidance on the required action when abuse was suspected. This meant the home had taken steps to protect people from the risk of abuse.

The registered manager had kept CQC informed about safeguarding incidents which had taken place in the service. Staff were aware of the whistle blowing policy and knew the processes for taking serious concerns to appropriate agencies outside of the service if they felt they were not being dealt with effectively.

Staff told us that they had not received training in behaviour which might challenge them and one member of staff told us that they would benefit from this so that they had the skills to protect people when they were distressed. However, they told us that the registered manager had talked with them about what to do when people were behaving in a way which people may find challenging. For example, they said they were encouraged to spend time to support people them to feel calmer, perhaps by going out for a walk or sitting quietly with them.

We asked the registered manager how they decided on staffing levels. They told us that staffing levels depended on the numbers and dependency levels of the people living at the home at any time. They explained that during the day time for the current occupancy there were three nurses on duty supported by eight or nine care staff. At night there were two nurses on duty and three care staff. The registered manager used a staffing tool to calculate safe staffing levels. The service also employed domestic staff, a chef and an activity coordinator. The registered manager told us they considered skill mix and experience when drawing up the rota and that they did not use agency staff. We spoke with staff about this and they confirmed what the registered manager told us. Staff told us there were enough staff on duty at all times to meet people's needs and not feel rushed. Our observations on the day of inspection confirmed there were sufficient staff to care for people safely.

Risk assessments were in place for each person who lived at the home. These covered such areas as falls, mental health and nutrition and were regularly reviewed. One person was not able to use a call bell and a risk assessment was in place to ensure this person had a regular check. The registered manager told us that risks were assessed and the information acted upon to protect people. For example, one person was involved in a reassessment of risk after they fell which resulted in buying improved footwear. There were also risk assessments for security, falls, bed rails, infection control, emergency staffing, legionella and the use of hoists. These had all been updated in May 2015.

We looked at the recruitment records for three staff. These showed that safe recruitment practices were followed. Recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) were present for each member of staff and two references were obtained before staff began work. The DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. Nurses were checked to ensure they were registered with the Nursing and Midwifery Council (NMC) and the registered manager kept a record of the personal identification numbers numbers. This meant that the provider had taken steps to reduce the risk of

employing unsuitable staff.

All areas of the home were accessible, and a lift was available to the upper floor. Environmental risk assessments were in place and each person had a Personal Emergency Evacuation Plan (PEEP) to protect them in the event of fire. PEEPS are used to record the assistance people would need to evacuate the premises in an emergency, including any impairment they had, the support they would need from staff and any equipment they would need to use.

We saw that entry to the home was controlled and there were keypads on the exit and internal doors for people's safety. Health and safety checks were regularly carried out as part of the quality monitoring system and any required actions were acted upon. We looked at a sample of safety monitoring checks for services and systems and found they were up to date and any shortfalls had been acted upon.

The service had an up to date fire risk assessment and fire equipment was checked and in place.

Staff told us that they had received training in the control of infection during their induction and had received regular updates. They correctly described how to minimise the risk of infection. They spoke of the correct use of aprons and gloves and also told us that they washed their hands frequently and always between offering care to people. The service had an infection control policy and procedure which staff told us they followed. This included details of how to manage outbreaks of infection. The laundry room had a suitable washing machine and dryer. Dirty and clean laundry were kept separate to minimise the risk of cross infection.

Good

Is the service effective?

Our findings

People told us that they enjoyed the meals. One person told us, "The food is nice." Another person said, "The food is good. Too good sometimes!" We observed people enjoying the lunch time experience. A health care professional told us, "Staff are very good. They have good morale. They go above and beyond to help people."

Staff had received induction and training in all areas considered essential by the registered provider. This was completed with a plan in place for when this needed to be renewed. In addition, the registered manager had sourced training in dementia care. Staff told us that their training supported them to offer personalised and safe care for people.

Staff received regular supervision support. This included dementia care appraisal, staff assessment of their own performance in discussion with a supervisor and practical supervision of care tasks. Staff told us that their supervision supported them to offer safe, good quality care, and the records confirmed that such supervision discussions had taken place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People's plans of care showed that the principles of the MCA Code of Practice had been used when assessing people's ability to make decisions. The service also had a policy and procedure on the MCA and DoLS to protect people. Staff understood the principles of the MCA and DoLS.

Plans tended to consider a person's overall mental capacity rather than focusing on their capacity to make decisions about each area of their care. However, when Best Interest decisions were required these had been arranged appropriately. For example, a Best Interests meeting had been held to decide whether a person would remain at the service. The registered manager had recorded discussions with relatives, staff and the GP. A Best Interests Decision is made when a person does not have the capacity to make a decision for themselves and involves a multidisciplinary team.

A number of DoLS authorisations had been applied for and granted which were subject to review. Records confirmed that these had been applied for and put into place appropriately and that the decisions had been made in the person's best interests.

People's consent to care and treatment was recorded along with their capacity to make decisions about their care. Where appropriate, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) consent forms were correctly completed with the relevant signatures. However, one DNACPR record had not been updated appropriately and it was unclear if a relative had been involved when this would have been expected.

Needs relating to nutrition and hydration were recorded in care plans, and risk assessments were available in associated areas such as pressure care and choking. The service used the Malnutrition Universal Screening Tool (MUST) which is a five step tool for assessing whether adults are at risk of malnutrition. People's likes and dislikes around food and drink were recorded and staff were aware of what these were. Charts were used when necessary to monitor people's food and drink intake and these were accurately completed with no gaps. Information from charts was used to ensure care plans were up to date and relevant to people's changing needs. The registered manager referred people for specialist support when this was needed; for example, to the Speech and Language Therapy service (SALT).

We observed a meal time. Tables were attractively laid with tablecloths, cloth napkins, glass and china. Jugs of juice were available on tables. We observed a pleasant atmosphere. Staff showed people the food options so that they were able to choose what they preferred. They supported people at their own pace and were friendly and attentive. They showed that they understood people's eating preferences, for example, supporting a person who did not wish to sit at a table but was content to eat standing up by a window and who was provided with finger foods they were able to manage independently. Snacks and drinks were available throughout the day and staff responded to people's requests. For example, they brought a person lemonade and crisps when they asked for this.

We spoke with a chef, who told us that they had information about people's likes, dislikes and allergies. They also had information on specialist diets and whether people required their food to be presented in a pureed or other adapted way. They worked to a four week menu and had a meeting with the people who lived at the service every six months to discuss menus and food preferences. The chef told us that they used fresh meat, vegetables and fruit. This meant that efforts had been made to meet people's dietary needs and preferences.

The registered manager told us that medical conditions which required monitoring were managed in consultation with health care professionals and that risk assessments, for example in relation to falls were in place. Examples of health care professional consultation were available on people's care plans. The registered manager told us that staff handover between shifts was a useful way of ensuring staff understood any changes in people's care needs and whether there was any involvement or advice to pass on to them from health care professionals.

A health care professional told us, "Staff continue to carry out the support I recommend. Such as exercises. I feel part of the team. It's a fabulous place."

Staff also routinely supported people to attend GP and hospital appointments. Care plans showed that people had been seen by a range of health care professionals including GPs, dentists and district nurses. The records showed that staff contacted health care professionals to resolve issues, including the Community Mental Health Team. The staff team maintained records of all specialist involvement. We saw care workers had involved GPs and other health care professionals in a timely way and kept clear notes about consultations. The support guidelines for this were written into care plans with people's involvement and consent where relevant.

The environment was well adapted to the needs of people who were living with dementia. For example

there were textile pictures, and tactile objects on the walls to provide stimulation. Memory boxes were on the walls containing objects which reminded people of their interests or people who were important to them. Blue tape had been fitted to the bottom of the door of a person with a visual impairment to make it easier for them to recognise their door.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person told us, "It's fine here." Another person said, "It's very nice here. Staff are very pleasant. There is always someone to talk to here." A relative told us. "There are good relations with staff. I have been in discussions about the care," and, "Staff keep me informed." One visitor said, "Once I was in [my relative's] room and they didn't see me when they came in at first and I was really impressed how kind they were to [them] before they even noticed me."

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. Staff knocked on people's bedroom doors before entry. People were comfortable and happy around staff. Staff gave the impression that they had time and spoke with people in a reassuring and calm manner. They interacted well with people, adjusting their approach according to each person's needs. For example, one member of staff read a letter to a person and then offered to put it safely in their room.

The reception area of the home contained a 'family tree' with staff names, photographs and role written onto it, to inform people who lived at the home and their visitors about the staff group.

The staff and people we spoke with told us that the home encouraged visitors at any reasonable hour and we observed that a number of visitors were greeted by staff in a friendly way. A visitor told us that the staff always offered them refreshment and that they involved them in discussions about their relative's care when this was appropriate. They told us that the registered manager and staff all demonstrated care and understanding of people's needs.

People told us that staff responded quickly when they asked for help and that they did so cheerfully. A health care professional told us, "There is no disrespect here. One [person] can be rude to staff but they are always professional."

Staff understood the importance of respecting people's privacy and dignity. People were approached discreetly with regard to their personal care needs. They were encouraged and reassured in situations where they may be unsure, such as when being assisted to move.

The service had a policy and procedure on respecting equality and diversity and we observed that staff treated people as though every individual was valued and that they mattered.

People who had difficulty communicating verbally were enabled to give their views through staff spending time with them, listening and observing body language. We observed that people's meal choices and preferences about where they were in the home were gained in this way. Nobody required specialist equipment in order to communicate, and those people who had cognitive impairments were given considerate attention.

When we asked the registered manager how people were placed at the heart of their care they told us that the staff were observant, and that they had regular meetings to discuss whether people's needs had

changed. Staff told us they observed people for signs of pain or discomfort and acted quickly to alleviate this. Our observations confirmed that staff were kind and responsive to people's emotional needs.

Good

Is the service responsive?

Our findings

People told us that the service was responsive to their needs. One person told us, "It's very nice here. I sit outside in the summer. The food is very good. We get out a lot in the summer. Last year we went on a canal trip." A visiting health professional said, "I think it's brilliant. The best home I have ever been to. The activity organiser is great." A visitor told us, "If you make suggestions to staff they are responsive. I have no concerns or complaints. They try to involve the local community and invite them to events here." Another visitor stated, "I couldn't have found a better home. It turns out [my relative] was in pain but because of [their] dementia [they] couldn't say. Whereas now [they have] a pain patch and are so much happier."

Written care plans were regularly reviewed. It was clear from the records that efforts had been made to involve the person and those they wanted to be consulted in this process, either through people signing or by staff writing records of what the person had said and preferred. Reviews focused on wellbeing and any improvements which could be made to people's care. Relevant specialists were consulted for advice at these reviews. Monthly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care.

People had identified areas of interest, likes, dislikes and preferences within their care plans. People's life histories were recorded with their permission. Where people did not have the mental capacity to give a view, efforts had been made to consult with others who were important to them.

A member of staff was employed to engage people in activities. Examples included walks, shopping trips, games, quizzes, hand and eye coordination games and reminiscence. In the afternoon staff supported people to play a game which involved kicking a giant ball amongst them. People were clearly enjoying this. There were many stimulating items in the communal areas of the home such as bags, clothing, jewellery, books and magazines. We observed people engaging with these as they sat in the lounges or walked around the corridors.

A small number of staff were not fully confident in their interactions with people, which resulted in people looking for something to occupy them. This meant that these staff were not always responsive to people's need for social stimulation. However, other staff were very confident in generating conversation and engaging residents. Overall we observed that staff were generally responsive to people's needs.

One person indicated that they would like to wash up the dishes after dinner and was supported to wash and dry which they enjoyed. Staff told us that this person became distressed at times, and that to assist in this way gave them a focus. Another person went into the kitchen area and began to challenge this person. Staff diffused the situation and moved the second person into another area in a skilled and thoughtful way.

Some people had a paper flower on their door. The petals describe some of their interests, likes and dislikes which helped to remind staff what was important to people. For example, one person's petals showed they liked dancing, hugs and hand massage.

The registered manager told us about a project being carried out in the home in conjunction with Pioneer Projects who supply two artists to support staff to engage people who were living with dementia in craft sessions. Staff told us that they were now more confident in understanding how art and craft could benefit people who were living with dementia, and how best to approach this type of activity.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs.

Staff could tell us about people's care needs and how these had changed. They explained how referrals to health care professionals had been made to ensure care remained appropriate for each person. Records confirmed this.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously, though all told us they had never made any formal complaints. We saw that the service had a complaints procedure and that this was displayed in the entrance to the home. Staff told us this was followed. The home has received no complaints over the past year.

Good

Is the service well-led?

Our findings

People we spoke with told us they thought the home was well run and that the manager was always available for people to talk with them.

The home had a registered manager in post. The registered manager had a clear understanding of her role. Staff told us that the team discussed each person's care daily and passed on any information between shifts. Staff told us that the lines of communication to and from the registered provider were clear and they knew who to go to for support. They felt consulted and encouraged to give their views to the registered manager about how to improve care. This meant that staff views were sought and acted upon for people's benefit.

The registered manager held meetings with staff to discuss individual people's care, to consult with staff and to pass on important information. Staff meeting minutes confirmed that the agenda covered a varied range of subjects and showed that staff were supported and encouraged to improve people's care. However, staff meetings had not taken place as often as was planned, and the registered manager had kept an interim record of discussions, daily updates and weekly senior staff meetings along with feedback shared with staff.

A member of staff told us, "I feel supported and always get on with the manager." Another member of staff said, "The manager checks how I am getting on. The manager is lovely. The best manager I've had. [They are] very friendly and always say 'thank you'." Another member of staff said, "They then inform us of any decisions. We are able to put ideas to the head of unit."

The activities coordinator held meetings with people who lived at the home in order to find out their opinion on such areas as meals, activities, and any concerns or complaints. The registered manager told us that they also met with people on an informal basis to seek their views.

People who lived at the service told us the registered manager often spoke with them, asked how they were feeling, and if they would like anything to be changed. Visitors told us that the registered manager usually spoke with them whenever they visited. They told us they were consulted regularly and at monthly reviews.

Staff told us that they were well supported by the registered manager, that they were regularly consulted and had the opportunity to pass on any concerns and to discuss areas for improvement. They told us that the staff team was supportive of each other and that the ethos of quality care applied to them as staff too, as well as the people being cared for. This made them feel valued and keen to offer their best.

There were systems and procedures in place to monitor and assess the quality of the service. For example, we saw records of audits such as infection control, record keeping, medicines, and health and safety. Audits also included areas of people's care including their involvement in decisions about their care, whether care was personalised, staffing levels and training. The registered manager had surveyed people who lived at the service and visitors for their views. The feedback from this had not yet been collated and shared with people, but the registered manager planned to do so.

Throughout our inspection the registered manager demonstrated a passion and commitment to provide good care. Staff and those people we spoke with all told us that they respected the registered manager who was well liked.

The service had sent CQC required statutory notifications, and the registered manager was aware of their responsibilities in relation to other organisations such as the Health and Safety Executive and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured that people were protected by the way medicines were managed with regard to covert medicines.