Speciality Care (EMI) Limited

The Oaks

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

This unannounced inspection took place on 18, 19, 27 and 30 March 2015.

The Oaks is a nursing home which can accommodate up to 113 older people with dementia or mental health issues across six units. The home is located in New Eltham, south east London. There were 85 people using the service at the time of our first inspection visit.

We last inspected the Oaks in March 2014. At that inspection we found the service was meeting all the regulations that we assessed.

A registered manager was not in post at the time of our inspection. 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. A new manager had recently started work at the Oaks and they had commenced their application for registration with CQC.

Prescribed medicines were available and administration records were up to date on five units. These showed that

Summary of findings

the people on these units were receiving their medicines regularly and as prescribed. The arrangements for the management of people's medicines on one unit were found to require improvement. You can see what action we told the provider to take at the back of the full version of this report.

Most of the people told us they were happy and well looked after. We observed positive relationships between staff and people at the service and their visitors. Staff knew people's needs and preferences well and treated people in a kind and dignified manner.

There were clear procedures in place to recognise and respond to abuse and staff had been trained in how to follow these. Staffing numbers were sufficient to help make sure people were kept safe.

Risk assessments were in place and reflected current risks for people at the service and ways to try and reduce these. Care plans were in place and being reviewed to ensure the care provided was appropriate for people. Equipment at the service was well maintained and monitored and regular checks were undertaken to ensure the safety and suitability of the premises.

Staff received training to help them undertake their role and were supported through regular supervision and appraisal. We saw staff had received training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). They were aware of people who did not have the capacity to consent to some aspects of their care and the importance of working in their best interests.

The mealtime experience for the people living at the Oaks could be improved. Accurate and accessible information about the meals provided was not consistently being given to people using the service. People did not always have choices about the amount and variety of food they were served. The mealtimes we observed were task focused with little emphasis on them being a social occasion and an opportunity for interaction.

People had access to a range of health and social care professionals when required. They and their relatives or friends were supported sensitively in end of life care.

Effective systems were not fully in place to regularly assess and monitor the quality of services people received or make the improvements required. The medicine audits had not picked up and rectified the shortfalls we found during our inspection.

There was a positive culture at the home where people felt included and consulted. People and their visitors commented positively about the acting manager. They felt confident they could share any concerns and these would be acted upon.

Work was taking place to update the premises and replace items of furniture. We have made a recommendation for the provider to look at ways of making the environment more dementia friendly.

Summary of findings

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

Some aspects of this service were not safe. Further improvements were required to ensure that medicines were being managed safely.

Risks to people were being managed safely.

There were enough staff on duty to help meet the needs of people using the service.

Staff were recruited safely and knew how to recognise and report abuse to help keep people using the service safe.

Is the service effective?

Requires Improvement

Some aspects of this service were not effective. Staff provided appropriate support to those who required assistance with their meals. The mealtime experience for people could, however, be improved.

People were supported by staff who had the necessary knowledge and skills to help meet people's needs.

People were able to see health care professionals as required to ensure their health needs were met and had access to specialist advice and support as needed.

The service complied with the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People using the service and their visitors were happy with the care they received. People spoke positively about staff and said they were kind and caring.

Staff knew people's needs and preferences well and treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive. Care plans were drawn up in consultation with people or their relatives when appropriate. They outlined people's care and support needs and were regularly updated.

Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

People and their relatives said they knew about the service's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Summary of findings

Is the service well-led?

The service was not always well-led. There had been changes of manager. A new manager had been appointed.

The provider had systems to regularly assess and monitor the quality of services people received . The quality assurance process for the management of medicines was not effective.

Requires Improvement

The Oaks

Detailed findings

Background to this inspection

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

Before the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by.

We visited the home on 18, 19, 27 and 30 March 2015. Our visits were unannounced and the inspection team consisted of three inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we spoke with seven people using the service, 12 visitors, 15 care staff, the operations director, the acting manager and two deputy managers. We also spoke with two visiting healthcare professionals. We observed care and support in communal areas, spoke with people in private and looked at the care records for 15 people. We also looked at records that related to how the home was managed.

We 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 could not talk with us.

Requires Improvement

Is the service safe?

Our findings

We checked the service's arrangements for the management of people's medicines by checking a sample of medicines records and medicines supplies for 50 people throughout the home. All prescribed medicines were available, and medicines records were clear and up to date on five units. This showed that people on these units were receiving their medicines regularly and as prescribed, however, we found issues with the recording and use of medicines on one unit.

On this unit, we found that records of medicines administered to people were unclear and incomplete. For example, two people's prescribed controlled drugs had been transferred to another unit, but the transfer of their controlled drugs had not been recorded in the controlled drugs register. Two people had allergies to medicines, but this information had not been transcribed onto their medicines records. The dose of one person's medicine for blood disorders had not been clearly recorded on their medicines record, which increased the risk of this medicine being given incorrectly. Staff did not always make a record when prescribed creams were applied which meant there was a risk that people may not receive these medicines correctly. Two people were prescribed sedating medicines to be used only when needed if they became distressed. When we checked supplies of these medicines against entries for administration on their medicines records, we found discrepancies. The number of doses signed for as administered did not tally with the number of doses used. The reason for administering doses of these medicines had not been recorded on their medicines records or daily notes. Protocols explaining under what circumstances to administer these medicines were either not available or had not been updated when these medicines were changed. This meant that staff did not have sufficient information to administer these medicines correctly and there was no evidence that these medicines had been administered in appropriate circumstances.

These shortfalls were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We highlighted the issues with medicines on this unit to the manager on 28 March 2015. We returned to the service on 30 March 2015 and we saw that the manager had taken immediate action. They had already addressed some of the issues found and later supplied us with a detailed action plan setting out the further actions they would be taking, such as medicines refresher training for staff, to make the necessary improvements with medicines.

We did see some areas of good practice with medicines. For example, we saw evidence that people's medicines were reviewed regularly by the GP. There was regular input by a psychiatrist for people with mental health issues or dementia. When people without capacity to consent to take their medicines were refusing medicines, placing their health at risk, suitable arrangements had been made to administer their medicines covertly, ensuring that these people continued to receive essential medicines. Medicines were stored securely on all units. The manager told us that the service was having difficulties obtaining accurate supplies of medicines from the pharmacy, but we saw that all supplies of prescribed medicines were available, as the manager had been proactive in attempting to resolve this issue.

People told us they felt safe living at the Oaks. Comments included, "I've never been troubled, overall a good little place" and "The people are alright, they work with you."

The majority of visitors we spoke said they felt people using the service were kept safe and were well cared for. One visitor said, "I can go home and sleep at night knowing they are ok." Another person visiting told us, "I have no concerns, we are very happy with the care."

Staff were aware of safeguarding procedures and confirmed they had completed training in this important area. They could describe what actions to take should they become aware of abuse or poor practice. Staff said they would take immediate action to protect the person at risk and report their concerns to their line manager. One staff member said "I would inform the nurse in charge. If they did not do anything, I would speak to the manager." Another staff member told us, "I've done the online learning, I'd report to the nurse." One staff member said they would contact the organisations head office if they felt they were not being listened to. Staff were aware of whistleblowing procedures and information about a confidential phone line for staff to ring was displayed in the home.

Requires Improvement

Is the service safe?

Safeguarding policies and procedures were available to staff with records kept of alerts to effectively audit their progress and enable learning from the outcome when known. For example, one record documented positive and negative outcomes from an investigation. Performace improvement plans had been implemented for staff to make sure the incident was used as an opportunity for learning.

Assessments took place which looked at any risks to people's safety and how these could be reduced. Risk assessments were completed for falls, bed rails, moving and handling, nutrition and skin integrity .Care plans were drawn up as appropriate following these assessments to help prevent or minimise the risk of harm to people using the service. For example, where there was a high risk identified of pressure sores, care plans addressed the equipment and support required such as turning people regularly when they were in bed. Turning charts were kept in people's rooms documenting the actions taken by staff.

A system for reporting accidents and incidents was in place. Each report was seen by a manager and these were monitored by the organisation with incident analysis taking place on a monthly basis. Examples were seen where changes had been made following a reported incident or accident. For example, an additional carer had been provided in one unit to help ensure the safety of people living and working there.

There were generally enough staff to help support people safely and in a timely manner. Some visitors said the units could be short of staff at times and said that staff were always very busy. One visitor commented, "On two days recently, the unit was very short of staff, but there is usually someone watching them."

A dependency tool was used by the organisation to identify the staffing hours required by people using the service and this was reviewed on a monthly basis. A ratio of one staff member to just under four people was maintained with a qualified nurse working on each unit. Rotas looked at confirmed these levels. Staff were protected from working excessively long hours with a maximum limit of 55 hours per week in place. Staff spoken with said that staffing levels were sufficient to meet the needs of people using the service. One staff member commented, "Four staff AM and four staff PM, it's good." Another person told us, "Four on each unit is good if managed well, the problem is staff cancelling at the last minute."

Recruitment was taking place at the time of inspection with vacancies having been filled but the organisation was awaiting criminal record checks for these new staff members. Rotas showed that consistent agency staff were being used to cover vacancies in the short term and staff said that carers came from other units whenever possible to help out if cover could not be found.

A new call bell system was being fitted at the time of our visit. This system alerted staff to calls for support using screens located in each unit and enabled assistance to be called from other parts of the home in the event of emergencies. Electronic records could be generated to monitor if calls were being answered promptly. Handsets and wall buttons were placed appropriately in bedrooms and communal areas and were within people's reach should they require support.

The layout of the home meant that some bedrooms were located at the end of corridors out of line of sight from the main communal areas and the office on each unit.. Staff were seen to regularly check where people were, however, we observed two instances where people living with dementia entered other people's bedrooms on two units without staff's knowledge. The acting manager demonstrated sensors that were being connected to the new call system to alert staff of movement in bedrooms where vulnerable people remained in bed or were at risk of falls.

Recruitment checks took place to make sure staff were suitable to work with people using the service. Five staff records looked at contained a employment history, two written references and a criminal record check. The provider also checked to make sure staff could legally work in the United Kingdom.

The premises were well-maintained and clean. Risks associated with environment and equipment were assessed and revierwed. Safety checks were regularly carried out such as those for the fire, gas and electrical equipment installed.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to meet their needs. One person using the service said, "Quite good staff." Another person said, "The staff are good". Comments we from visitors were positive and one person commented "[My relative] tells us how good they are to him. They do look after him well."

Staff completed online and classroom training relevant to their role and responsibilities. This included mandatory training to keep people safe, such as safeguarding adults, manual handling, medication and basic life support. One staff member said, "We have lots of training, staff are now serious about training" commenting that their attendance was monitored by the organisation. Two staff spoke positively about the 'creative minds' dementia training delivered in five modules addressing the impact of the disease, communication, distress, respect and meaningful activity. They said they had found this training helpful when working with people using the service.

Other training provided included sessions around diabetes, nutritional needs and the Mental Capacity Act 2005. There were systems to record the training that staff had completed and to identify when sessions needed to be repeated. Attendance was monitored by the organisation to make sure staff had completed the required training.

New staff completed a core induction programme and induction workbooks were being completed whilst individuals shadowed more experienced staff members on shift. A first day checklist was completed for each staff member confirming they had read and understood key procedures such as safeguarding, confidentiality and the home's philosophy of care. The induction took place for the first three months of the staff members six month probationary period with each part of the workbook signed off by the employee and their line manager. Other information provided to new staff included pressure care guidance and written health and safety policies.

Staff were supported through regular supervision and annual appraisals. Records seen confirmed this and staff told us that they received regular supervision at varying intervals between two and three months. They said they felt able to approach their line manager at any time for support.

Staff had received training in the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Information and prompts for staff were displayed in each unit office for staff to reference following their training. The MCA is a law about making decisions and what to do when people cannot make some decisions for themselves. The DoLS protect people when they are being cared for or treated in ways that deprive them of their liberty.

One staff member told us, "We make decisions in their best interests" if the person was assessed as not having capacity. Another staff member said, "Some people here do have capacity but for others who are not able, we try to anticipate their needs, liase with their family and discuss fully what is in their best interests. We then care plan around that information."

Care files seen included capacity assessments documenting the person's ability to understand, remember,weigh and communicate the information provided to them and look at what was in their best interests. A care plan for one person looked at them not being able to make a choice about their food and how staff should make choices based on their previous known preferences.

The organisation was aware of the Supreme Court ruling and had made applications to the local authority for DoLS authorisations for people using the service. The service had recognised that these applications were required because some people would not be free to leave the Oaks and they required continuous supervision by staff.

Visitors were positive about the food provided. One person told us their relative not been eating well but was putting on weight after coming to live at the Oaks. People were impressed that all the meals are freshly made and one visitor commented the person they knew was always given "plenty of food". Another visitor said that their relative used to struggle with the amount of food they were offered but was now given smaller meals. Care plans addressed people's nutritional requirements with screening assessments completed to help safeguard people from the risk of malnutrition. Pureed meals were made available to people using the service as required.

The mealtime experience for people using the service could, however, be improved. Both people using the service and staff on four units were unsure as to what was being served for lunch on the first two days we visited. Staff

Requires Improvement

Is the service effective?

on one unit told us, “We have to wait, we know when the trolley comes.” Staff on another unit were mistaken as to which week’s menus were being served and those working on a third unit had to look in the trolley to see what was served that day. Four weekly menus were displayed in some units however these were in small print and relied on staff to know what weeks menu was being served. An accessible menu board was displayed on one unit however the displayed information was wrong. It was unclear as to who took responsibility for updating this pictorial information. Condiments and sauces were also not routinely provided for people to use.

Meals were served plated and we did not see people routinely being given choice as to what or how much food they were served. Staff were inconsistent around telling people what they were eating with some saying “here is your food” whilst others were careful in telling people what they were about to eat. People who required help were given unhurried assistance to eat by staff and we saw visitors sitting helping people with their lunch. However, the numbers of people requiring assistance meant that some people had to wait to eat.

Televisions were left on throughout the mealtime during our observation on two units and some staff missed the opportunity to chat with people with little conversation taking place. This meant that the mealtime was task orientated rather than being a social occasion.

Staff supported people to access health care services when necessary. Information and contact numbers for accessing health services was displayed on each unit including the GP, optician and dentist. Weekly GP visits took place on each floor. Records showed that staff accessed more specialist health services such as psychiatry and tissue viability.

The home was undergoing renovations at the time of our visit with improvements being made to the communal areas of each unit. New bedroom furniture was delivered by the second day of our inspection and work was under way on one unit to ‘dress’ the environment with pictures along the hallways. A sensory room was planned and we saw there were further opportunities to make units more dementia friendly with more items for occupation and engagement. An easily accessible and sensory garden area would also benefit people in getting fresh air safely and having a change of surroundings.

We recommend the service finds out more about dementia friendly environments, based on current best practice, in relation to the specialist needs of the people living at the Oaks.

Good

Is the service caring?

Our findings

People who used the service and their visitors felt the staff were kind and treated people with respect. One person told us that the care their relative received was "excellent". Another visitor said "The nurses and staff have become like family to me, I couldn't praise them more. We come at different times and they are always on task." A third person told us that they were thankful that they could visit at different times every day. They said their relative was "in the best place and is looked after well." Another visitor told us, "They take such good care of [my relative], they phone about the smallest incident." Another person told us their relative was "Well looked after." One visitor was appreciative of one staff member who stayed with them at the hospital well into the evening after their shift had ended.

Our observation showed staff had good communication skills and were kind, caring and compassionate. It was evident they knew some individuals well, speaking to them in a kind and caring manner. We noted some staff pro-actively engaged with people however others were more task focused missing opportunities for interaction. Some staff used touch to reassure people, holding their hands when they were upset. For example, this pattern of care was found in the afternoon on two units when afternoon tea was being served. The staff talked gently to each person. We observed that the staff went to each person, offered a choice of biscuit and had a brief chat with them.

Visitors spoken with were not always aware of care plans for their relatives but told us they were happy with the care that was given. One visitor said they had been able to see their relatives's care plan and said staff were happy to share this information. People's care plans described the person's likes, dislikes and daily routines. Some of the care plans included advanced care plans. For example, where people's end of life needs had been assessed, appropriate records were in place to ensure their wishes were met.

People's preferences were met. Staff were able to tell us people's preferred form of address and how some people requested staff use their preferred first name. These names were recorded and used by staff. For example, we overheard one of the staff speak to a person using the title; Mr. this staff explained that the gentleman had requested this form of address. Other people in the unit were happy to have their first name used when spoken to.

Staff respected people's privacy and dignity. We saw staff knocked before entering people's rooms and wait for a response. They went in and introduced themselves and explained why they came in their room and what they would be doing when supporting them. Staff were able to give us examples of how they maintained people's privacy and dignity. For example, where people required support to eat, staff covered people's clothes with aprons. Staff removed the aprons as people finished their meals to help them maintain their dignity.

People's care records included details about people's ethnicity, preferred faith and culture. Staff were aware of people's cultural, religious and personal needs. All staff we spoke with showed an understanding of equality and diversity.

Managers from the service were due to attend an initial meeting with professionals from the community hospice. This was to discuss the roll out of the six steps to success end of life care programme for care homes at the Oaks in 2015/16. However, we could not assess the impact of this at the time of our inspection.

Good

Is the service responsive?

Our findings

People and their visitors told us they received care and support that met their needs. People were full of praise that they could visit their relatives at any time and stay as long as they liked. One visitor told us "Staff always have time to answer questions".

Care plans included a pre-assessment of people's needs before they moved into the home. A detailed care plan was in place which covered areas such as nutrition, personal care, communication, mobility and social, personal hygiene, skin care and social wellbeing. The level of physical support people needed, and what they were able to manage on their own was included in their care plan. Care plans included important personal details and assisted staff to effectively support and care for them. Care plans had been reviewed on a monthly basis and updated when there were changes to ensure that there was an up to date record for staff of how to meet people's needs. For example, the equipment people needed to ensure their safety and skin care management plan were in place. We saw that relatives were kept informed about any changes to their family member's health or support needs. However, we found in one case a person's care plan was not updated to reflect their mobility needs and the advice received from a physiotherapist. This was brought to the attention of the senior staff, who told us this would be actioned immediately. We were unable to assess the impact, as the actions were not completed at the time of our inspection.

Staff completed daily records relating to wellbeing and care which showed what support and care had been provided and the activities the person was involved in during the day. For example, information for each person on personal care, food and fluid intake, repositioning of people in bed and skin care management was recorded in people's care files.

The home provided a range of activities that people could choose to participate. We saw that planned activities were displayed around the home so people were kept informed of social events and activities they could choose to engage in. We saw that activities on offer included gardening, cooking, dogs' therapy, physical exercises, days out, celebrations of important events and birthdays and live entertainment from external entertainers. People using the service were supported in activities by two full time activity coordinators. A visitor told us they were very pleased one day recently to see their relative up and dancing to some music from the 50's. This was the first time that they wanted to participate in any activity. The visitor also told us they also witnessed a tea party with balloons and birthday cakes for two other people recently. After the morning tea and biscuits, people were who were interested were taken to a lounge to participate in some dog therapy. We observed the therapy team members and six dogs brought a lot of happiness to the people in the lounge. Two people had their own visitors at this time and they were able to take part too. One was a young person who delighted in helping their relative hold a small dog on their lap. We saw that these activities were having positive effect on people's wellbeing.

People's concerns were responded to and addressed. People and their visitors told us they knew how to complain and would do so if necessary. There was a system for reporting any concerns raised by people or their representatives. Complaints record showed that when concerns had been raised these were investigated and responded to appropriately to the complainant and where necessary meetings were held with the complainant to resolve their concerns. For example, staff levels had been improved by rearranging staff annual leave procedures and an occupational therapist and psychiatric nurse referral had been made.

Requires Improvement

Is the service well-led?

Our findings

There was positive culture at the home where people felt included and consulted. People commented positively about staff and the new manager. The atmosphere in the home was calm and staff were approachable. People and their visitors felt confident they could share any concerns and opinions and these would be acted upon. One visitor told us when they mentioned the need for more outdoor furniture in the gardens, this was acted on and their relative enjoyed spending time outside. Another visitor said "Staff talk to me. I so appreciate what they do, I always thank them. They have looked after my relative for 10 years." However aspects of the service were not well-led.

Effective systems were not fully in place to regularly assess and monitor the quality of services people received or the improvements required or actioned as a result of the audits. The medicine audits had not picked up and rectified the shortfalls we found during our inspection such as with the protocols for as required medicines or discrepancies in recording.

Regular staff meetings, monthly manager's audits, operations director's monthly visits, bed mattress and bed rail audits, relatives meetings and staff engagement surveys were carried out. At the time of the inspection a relatives and residents satisfaction survey was in progress. The visitors we spoke with told us they had been asked for feedback from the home. Where concerns in relation to people's changing needs, staff training needs, home environment and infrastructure needs were identified through quality monitoring, an appropriate action plan was put in place and progress monitored to ensure improvements were made. People's care records and the provider's management of organisation's records we saw confirmed this.

There was no registered manager in post. A new acting manager had been appointed three weeks before our inspection. At the time of inspection, the acting manager informed us that their application to be registered with CQC was in progress. All the people, visitors and visiting health care professionals we spoke with were aware of the recent managerial changes. One visitor said they noticed "different senior staff walk through the units to keep an eye on the residents and staff." Two health care professionals told us that change of managers' had been difficult and impacted on consistency and continuity of care delivery. One visiting professional told us the new manager and staff were good. The other professional told us the new manager had not yet been introduced to them, however, the two deputy managers and unit staff followed their advice and were good.

The acting manager and deputy managers interacted with people using the service, their relatives and staff in a positive and supportive manner. All of the staff feedback was positive about the new management. For example one staff member said "They listen and are ready to help us anytime, also, the deputy manager work on shift some days and that is a great help for us." Another staff member told us "The new manager is briliiant and proactive" giving examples where "someone's chair was not suitable and the manager is arranging for a recliner chair. And when staff report absent due to an emergency, agency staff are arranged on the shift." A third staff member told us "the manager always ensures there are right amount of staff on all shifts" and "when I have any concern about a person using the service, the manager listens you feel valued and the manager provides immediate support, for example they contact the GP without delay."

Staff recorded accidents and incidents which happened at the home. The manager used this information to investigate, monitor and took action where required. For example, when someone was discharged from hospital with bruises and skin infection, a safeguarding referral was made to the local authority, CQC was notified and care plan was updated with appropriate guidelines for staff to deliver care in bed on a airflow pressure relieving mattress. In another instance when someone's wrist was found swollen due to their behaviour, their family was informed, timely external healthcare support was sought and the person was given additional support and reassurance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that people were not being protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, and using, of medicines used for the purposes of the regulated activity. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and Regulation 12(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.