Hoylake Cottage

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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?	**Good**

Summary of findings

Overall summary

The inspection took place on 6 and 7 December 2016 and was unannounced. Hoylake Cottage is a three storey, purpose-built care home that is registered to provide accommodation and nursing care for up to 62 people. The ground floor and first floor units each provided nursing care for up to 20 people, and the second floor unit provided nursing care for up to 22 people who were living with dementia.

The home did not have a registered manager. 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. The previous manager had left the service in October 2016 and a new manager had submitted an application for registration with the CQC.

During our last inspection we found breaches of the regulations of the Health and Social Care Act Act 2008 relating to safeguarding arrangements; staff training and support; consent and capacity; and quality assurance processes. During this inspection we found that, in all of these areas, the new management team had taken action and there were robust plans in place for future development.

During this inspection, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's medicines were not always managed safely. You can see what action we told the provider to take at the back of the full version of this report.

All of the people we spoke with said they felt safe at Hoylake Cottage. We observed that the premises were clean and people had spacious and well-appointed bedrooms with en-suite toilet and shower. Maintenance contracts were in place and the home's maintenance team carried out some regular safety checks, however these were not comprehensive and the manager had arranged for a full health and safety audit to be carried out by an external company.

We saw that accident records were completed in full and were summarised monthly. Personal emergency plans were in place to advise how people should be evacuated safely in the event of an emergency situation.

There were enough staff to meet people's needs and the staff we spoke with were friendly and helpful. We looked at the personnel files of eight staff. All files had appropriate application forms with references and appropriate criminal record checks. This meant that the provider had ensured staff were safe and suitable to work with vulnerable people prior to employment. Since our last inspection, the service had employed an in-house trainer.

Everyone said they got enough to eat and drink, and most people were satisfied with the quality of the food. We saw room for improvement in the dining experience.

The second floor unit included some aspects of a dementia friendly environment, for example low windows

in the lounges enabled people sitting in chairs to see the garden and courtyard areas, however we observed that there was little stimulation for people in the environment.

People told us they could make choices about their daily routines and that their privacy and dignity were respected at all times. Everyone was very complimentary about the attitude of the staff and many said "They can't do enough for you." All of the visitors we met said they or another family member had been involved in care planning. Everyone said that visitors were welcome at any time, and there was a steady flow of visitors throughout the day. A variety of social activities was provided.

The home's complaints procedure was displayed in the entrance area. It gave the names and contact details of people who could be contacted if someone wished to make a complaint or raise a concern. Everyone we spoke with knew how to complain, but nobody had. A frequent comment was "I've nothing to complain about."

People we spoke with were aware the management had changed recently and many commented on the improvements that had been made already. Everyone thought the home was well run. We found that the management team were enthusiastic and committed to taking the home forward. The new manager had developed a quality assurance system which was being implemented at the time of the inspection.

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 entirely safe.

People who used the service were protected from abuse.

There were enough staff to provide care and support for people.

Not all of the equipment used in the home had regular safety checks.

People's medication was not always well managed.

Is the service effective?

Requires Improvement

The service was not entirely effective.

A programme of staff training was in place.

The home complied with the requirements of the Mental Capacity Act.

People received enough to eat and drink, but there was scope for improvement in the meal-time experience.

The home environment was functional but provided little stimulation, in particular for people living with dementia.

Is the service caring?

Good

The service was caring.

People who lived at the home, and their relatives, were very happy with the staff team and described them as kind and caring.

We observed positive and respectful interactions between staff and the people who used the service and their relatives.

Is the service responsive?

Good

The service was responsive.

People were able to exercise choices in daily living.

New care plans had been introduced and were written in a person-centred style.

A variety of social activities was provided.

Information about how to make a complaint was available for people.

Is the service well-led?

Good

The service was well led.

The home had a new management team who were enthusiastic and committed to taking the service forward.

The management style was open and inclusive.

A programme of quality audits had been prepared and was being implemented.

Hoylake Cottage

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.

The inspection took place on 6 and 7 December 2016 and was unannounced. The inspection team consisted of two Adult Social Care inspectors 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 care service.

During the inspection we spoke with five people who lived at the home, six visitors, the manager, the clinical nurse manager, and ten other members of the staff team. We looked at the care records of five people who used the service. We looked at staff records, health and safety records, medication, and management records.

Requires Improvement

Is the service safe?

Our findings

During the inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) because people's medicines were not always managed safely.

We looked at the arrangements for the ordering, storage and administration of medicines. At our last inspection of the home we found that improvements were needed to medicines management. Since that inspection, medicine cabinets had been installed in all bedrooms and people's medicines were kept in their own rooms. This meant that medicine rounds took a long time to complete, for example on the first floor the morning medicines were still being given at 11:10am and on the second floor morning medicines were still being given at 12:50pm. This meant that people were not receiving their medication at the correct time.

Medicines were administered to people by nursing staff. We were told no people at the home had been found to have the capacity to self-medicate. Nurses we spoke with said that a medicines round could take a long time to complete. In particular, on the second floor some people needed considerable support to take their medication. Sometimes people did not want to take their medication and this had to be taken back to their bedroom and locked in their medication cabinet then offered again later. Care staff, including those who had NVQ level 3, were currently not permitted to support people to take their medicines.

Most medication was administered via a monitored dosage system. Individual named boxes or bottles contained medication which had not been dispensed in the monitored dosage system. We looked at a sample of records and found that there were a number of gaps, missing signatures, on the medication administration records (MARs) where it was impossible to tell if medicines or creams had been given or not. We checked the MARs against the actual stock of medicines for some people and found that, although most medication was administered as prescribed, there were some discrepancies. We saw that medicines had been given but not signed for and signed for but not given. There were no running totals of the non-blistered medication which meant that any errors or discrepancies were not identified until the remaining stock was counted at the end of the month.

We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked and signed by two nurses.

We saw that 'when required' (PRN) medicines were not always supported by any written guidance to describe the situations and presentations where PRN medicines should be given. Without clear protocols there is a risk of inconsistent decisions about when the medication should be given.

We saw that some people did not always want to take their medicines and they were given their medication covertly, ie by hiding medication in food or drinks. We looked at the care files for two people who were given their medicines in this way. They did not have the correct paperwork in place to describe which medicines were essential to the individual's health and to confirm that a pharmacist had been consulted to check how to give the medicines safely hidden in food or drink.

Monthly repeat prescriptions were delivered to the home the day before they were due to start. This did not allow adequate time for the order to be checked and any missing items to be reordered to ensure that a new supply would be available.

The management team had already identified that improvements were needed to medicines management and had arranged a meeting with the medicines manager from the health centre and the pharmacy technician. They were going to provide support for the home to put new medication procedures in place. The manager had introduced a reflective practice form for nurses to use when a medication error had been made. A new monthly medicines audit had been started in November 2106 and had identified issues that need to be addressed.

All of the people we spoke with said they felt safe at Hoylake Cottage. A relative told us "She's extremely safe here, we couldn't ask for a better care package, we cannot fault the place."

Policies and procedures were in place for safeguarding vulnerable people from abuse. The home also had a copy of Wirral Council's safeguarding guidance. Safeguarding information was posted in the corridors giving phone numbers for people to call with any concerns. We saw records to show that appropriate safeguarding referrals had been made to the local authority and copied to CQC.

The home's trainer made sure the staff had read and signed the whistleblowing policy. On speaking to the staff, they were aware of what their responsibilities were and all said that they would have no hesitation in reporting anything untoward. All were able to tell us about their training and were able to say what actions they would take and who they would go to if they suspected abuse.

We asked people if they thought there were enough staff on duty. One person told us "Yes, if I press the buzzer they're here in no time." Another person said "I can always find somebody when I need them." Visiting relatives told us "I've never not been able to find somebody, ideally they could do with more, but you can always find somebody." and "There's loads of staff, about five or six in the lounge, they're really friendly."

Staff rotas showed that on both the ground and first floor units there was a nurse on duty throughout the day with four care staff in the day, three in the evening, and two at night. On the second floor dementia care unit, there was a nurse and five care staff on duty throughout the day, and two care staff at night. There were two nurses on duty at night to cover the three units. The business manager and the clinical nurse manager were supernumerary to the staff rota. Both were registered nurses so could provide nurse cover if needed. A total of 22 nurses, 60 health care assistants, and 45 ancillary staff were employed. The manager told us that there was only one remaining staff vacancy which was for a part-time night nurse. This vacancy was being covered by a nurse from an agency. The use of agency staff had reduced significantly which meant that there was more continuity for the people who lived at the home.

We looked at eight staff personnel files. All files had completed application forms with references and appropriate criminal record checks. The references had not been verified. This was brought to the attention of the new management team and the reference request letter was immediately adapted so that references could be easily verified in future.

During our visit we observed that all parts of the building were clean and there were no unpleasant smells. A house keeper was on duty on each of the three floors. Gloves and aprons were provided for staff to use when providing personal care. Hand-washing facilities were available in people's bedrooms and in clinical areas and were well stocked with liquid soap and paper towels. The laundry was spacious and well-equipped and was clean and tidy.

An NHS infection control audit in March 2016 recorded a score of 89% and identified some areas for improvement, most of which had been addressed. We discussed with the management team that the hand-washing sinks were small and were situated low down on the wall. This would make it difficult for staff to wash their hands thoroughly in the recommended manner. They agreed to consider replacement of these sinks as part of the future development plan.

The service employed three maintenance workers. The maintenance team carried out some health and safety checks of the environment and of equipment, but these were not comprehensive. For example, they did not regularly check bedrails, slings, pressure mattresses, wheelchairs or the nurse call system, but relied on nursing staff to report any issues. A communication book was used to report any health and safety or maintenance issues, and we were told that this was checked daily by the maintenance team. While walking around the building we noticed some doors that had a sign on saying 'keep locked' were not locked.

We noticed that the pressure mattresses on two people's beds were on the maximum weight setting. We looked at these people's care plans, which confirmed that they were not large people, and found no record of what the pressure mattress setting should be. There was no system in place to check that pressure relieving mattresses were at the correct setting to provide people with protection against tissue damage.

A fire risk assessment and plan was in place dated 4 October 2016. We did not see any evidence of fire drills being held. Fire evacuation aids were provided on staircases, however it is important to check that staff know how to use these by fire evacuation practices. Personal emergency plans were in place to advise how people should be evacuated safely in the event of an emergency situation and these were updated regularly by a member of the administration staff.

Where people were identified as being at risk of harm, risk assessments were in place and action had been taken to mitigate the risks. We saw where people were at high risk of falls, timely referrals were made to the Community Therapy and Falls Prevention Team. We looked at a number of beds with bed-rails in use or available to be used. We saw there was compatibility between the bed, mattress and bed-rail to prevent serious injuries from ill-fitting appliances. We saw that accident records were completed in full and were summarised monthly.

Records showed that regular Legionella testing was carried out. The five yearly electrical installations certificate was dated 13 November 2013. Portable appliances were tested in May 2016. The gas safety certificate had expired and the manager took immediate action to arrange re-testing the next day. Portable and fixed hoists were checked and serviced six monthly.

The management team had already identified that improvements may be needed to health and safety arrangements in the home and had booked a full health and safety inspection to be carried out by an external company. They had held a meeting with the maintenance team and were reviewing roles and responsibilities.

Requires Improvement

Is the service effective?

Our findings

We asked people if they got enough to eat and drink and everyone said "yes". One person said "I get more than enough." We asked people what the food was like and they told us "It's very nice, they give you a choice."; "It's very good."; "Things are getting better, but there's too much cream. I don't think I was asked when they changed the menus." A visitor told us "I think the staff know what Mum likes and doesn't like" and another relative said "We were asked what Dad's likes and dislikes when he came in."

We observed lunch on the dementia unit. The food looked appetising when it was served, but it was served on small white plates which may not be the best option for people with dementia. A visitor told us "He's on a pureed diet and it's all served separately.", however we saw that although the pureed diet was served separately, one carer mixed it all together.

On the second floor there were plenty of staff to assist people who needed support and people were able to eat at their own pace. The dining room lacked atmosphere, there were no tablecloths or place mats, cutlery was only given out when the food was served. There were no condiments on the table and when we mentioned this to a member of staff we were told salt and vinegar were available on a side table, however we didn't hear people being offered this. There were no napkins, just pieces of blue paper towel and not everyone was given this. There were no menus in the dining rooms.

On the nursing floors, staff were either sitting next to people in the dining room or in their own rooms when supporting them with eating. This was done with patience and a caring attitude. The atmosphere observed in the dining rooms was calm and good humoured. We saw staff offering people alternative choices for their dessert as they didn't want what was on offer. Staff were able to tell us about people who were diabetic, needed soft diets or were unable to eat certain foods. We saw no evidence that the people who required a soft or pureed diet were offered a choice of meal.

Two people commented that they would like to sit at a table where others were able to have a conversation with them. One person said "I went to the dining room the other day, but nobody talks to you."

In the care files we looked at we saw that nutritional risk assessments had been completed which identified if the person was at risk of malnutrition and reflected the level of support they required for eating and drinking. Where needed, staff recorded and monitored people's daily intake. A relative told us "They record everything." Records showed that people were weighed regularly in accordance with their care plans. Where a person had been identified as having swallowing difficulties, a referral had been made to a speech and language therapist.

Since our last inspection, the service had employed an on-site trainer who was given time to train staff in subjects such as safeguarding, dementia, food hygiene and infection control. We also saw that the trainer had trained staff on mental capacity. The managers told us that they were actively seeking additional training for the staff group. This included 'breakaway training' and 'challenging behaviour' training that had already been organised. This was done in partnership with another organisation.

Induction processes were under review by the new management as there was little evidence of a robust induction for new staff. We saw that the new manager had taken new staff through the induction standards and there was a plan for the Care Certificate to be implemented. Agency staff had an induction record.

We saw that all staff had received an appraisal and the staff we spoke with told us that they had found this helpful. The new management team had implemented clinical supervision of the nursing staff and planned to implement a supervision process for the care and ancillary staff. This was due to begin in January 2017. The manager had reviewed the staff handbook to ensure that it contained up to date information. We saw evidence that disciplinary procedures had been followed appropriately and according to the home's policy.

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 decisions made on their behalf must be in their best interests and be 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 procedures 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, and whether any conditions or authorisations to deprive a person of their liberty were being met and found that they were.

A large white-board in each of the staff offices showed which people had a DoLS in place and the expiry date, also which people had a 'do not resuscitate' order in place and the date of expiry. Staff we spoke with were able to tell us who had a DoLS in place. We saw mental capacity assessments recorded in people's care plans.

We looked all around the building and saw that everyone had a spacious bedroom with en suite shower and toilet. Some bedrooms were personalised with people's own belongings but others were rather bare. There was an assisted bathroom on each floor. The bathrooms were exceptionally clean and tidy but rather clinical. Everyone was provided with a fully adjustable bed, and pressure relieving mattresses and cushions were in use for people at risk of tissue damage.

The second floor had some aspects of a dementia friendly environment. Communal room doors used pictures and words of a size easily recognised. The home provided sufficient space to allow space between chairs to enable carers to help people with their needs. The lounge benefitted from low windows which enabled people to see the garden and courtyard areas. There was little stimulation for people in the environment, for example nothing tactile on the walls for people to touch, neither did we see any 'rummage boxes'.

On the top floor, the bedroom doors had a small plaque on them saying 'This room was sponsored by Wirral PCT'. This was clearly historic information as PCTs ceased to exist several years ago and did not add to a homely environment. We also noticed information stuck on to people's wardrobes, which again detracts from a homely ambience.

Good

Is the service caring?

Our findings

Everyone we spoke with said the staff were kind and caring. People said "They're marvellous, nothing's too much trouble for them"; "I find they're very nice, some are very friendly." and "They're very good, kind." A visitor told us "I can't fault them they're always caring." The expert by experience commented "Staff had a lovely attitude to the residents, they were helpful and very patient. They appeared to know the residents well and all were addressed by name as were the visitors. There was no evidence of residents being rushed."

Everyone we spoke with said that the staff protected their privacy and dignity. They always knocked before entering rooms. We asked people how the staff spoke to them and one person told us "They're very polite, and ask if they can do something before they do it." Visitors told us "Usually they are pretty good, some are better at it than others. I think you need a bit of experience to cope with this situation." and "They're great with her, sympathetic and understanding."

We observed that staff took time to listen to people and supported them to make their own choices, explaining the options available to them. This was particularly the case during meal-times when we observed staff taking time to ensure people understood the choices available. All of the staff interactions with people that we observed were friendly, respectful and caring and staff had an understanding of people's likes and dislikes.

People told us that their personal care needs were well met and visitors commented "The residents are always dressed lovely, the men always shaved."; "It's nice to see people all nice and clean." One person said "I'm just well looked after." We observed that people were well dressed. Their clothes were ironed and everyone looked very smart. The hairdresser was there on the first day we visited, but people who weren't having their hair done also looked well-presented and cared for. The hairdresser told us that she had been providing a service for the home for ten years and really enjoyed it.

Visiting was allowed at any time and there was a constant flow of visitors to the dementia unit throughout the morning. One visitor told us that relatives of people who had lived at the home but were now deceased still visited the home and were involved in the social activities.

On each floor there was a noticeboard with photographs and names of the staff team to help people identify individual members of the staff team.

Good

Is the service responsive?

Our findings

We asked relatives if they had been involved in the care planning and they told us "I've been consulted over it, it's reviewed every three to six months and you get a copy."; "Yes, they've asked about things, but I'm not aware of being given a copy."; "Yes, and I've been given a copy." and "It has been reviewed in the last six months."

We asked if people were able to make choices about their daily routine. One person told us "They get me up at 6.30 but I don't mind and I go to bed when I want." This person told us that was the time he got up at home. Another person said "I can decide for myself what I do." A third person said "I usually go to bed around 10. I have my breakfast in my room. The staff are aware of individual's needs."

All members of staff we spoke with were able to show their knowledge about the people they cared for. This included their health, dietary, personal care needs. They were also able to tell us about people's families and visitors.

We asked how staff found out about new people coming into the home and all staff were able to tell us about care plans, risk assessments and how information was handed over at the start of each shift. Pre-admission assessments were carried out by senior nurses to make sure that Hoylake Cottage would be a suitable home for the individual. Care files were fully accessible for the care staff to read and refer to.

The care plans we looked at were based on risk assessments covering mobilisation, continence, nutrition, communication, mood, sleeping, and personal hygiene. Care plans recorded what people were able to do for themselves and identified areas where the person required support. The care plans provided staff with clear guidance to follow when giving support and care. We saw that staff recorded outcomes of the care plan and the nurses reviewed the plans regularly and made adjustments where people's needs had changed. The care plans had been improved since our last inspection and were written in a more person-centred style.

Everyone living at the home was registered with a local health centre and a GP carried out a weekly visit. From looking at care plans, we could see that people were referred to relevant healthcare professionals as and when needed.

A relative told us "They have loads of activities and we're given the programme." The home employed a full-time activities coordinator who was quite new to the service but had considerable experience in a similar role and a national vocational qualification. She was supported by a number of volunteers who provided specific social activities for the people living at the home. She told us that she had recruited more volunteers and was just waiting for their Disclosure and Barring Service reports to be returned before they started working at the home. A regular programme of social events took place which included a weekly singing group, poetry reading, quizzes and games.

We asked people if they got the opportunity to go out and they told us "We went to see the Christmas lights

the other day."; "Yes, we've had meals out." and "We've been to see the Christmas lights and to a carol concert." A regular religious service was held and professional entertainment was provided once a month.

Some people chose not to join in the social activities and told us "I watch a lot of sport on television."; "I watch the telly or listen to the radio. I listen to CDs and watch DVDs." and "It's difficult to find someone to talk to, the staff come and talk to me. The activities are not for me."

Everyone we spoke with said they knew how to complain, but added comments including "I don't need to complain."; "I haven't got anything to complain about." and "I haven't needed to complain."

The home's complaints procedure was displayed in the entrance area. It gave the names and contact details, for example telephone number and/or email address, of anyone within the organisation who people could contact if they wished to make a complaint or raise a concern. The complaints procedure also referenced the CQC and the local authority. We saw records of one complaint received in 2016. This had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

Hoylake Cottage is a registered charity which provides daytime services and residential care. We asked people's opinions on how the service was run and everyone said it was well run. A visitor said "It's a very active trust and is well respected locally." Another relative said "I think it's well run, there's been noticeable changes with the new management."

Since our last inspection, a new management team had been formed. This comprised the business manager, who had applied for registration with CQC, the clinical nurse manager, the administration manager and the finance manager. These changes had only been finalised in October 2016 and the managers told us that they still had a lot of work to do to get the home running in the way they wanted. Both the manager and members of the Board had communicated well with CQC to keep us informed of the changes taking place.

It was evident from spending time with the management team that they were enthusiastic and committed to taking the service forward. The business manager and the clinical manager had support networks that included peer support and external support from clinical sources. There was currently a monthly Board meeting and sub-committees were being formed to have specific areas of oversight.

Visiting relatives told us "I think the management has a fantastic team." and "I've no qualms at all, they're very open."

We spoke with members of staff on the second floor. They told us that there had been a "huge change" with the new management team. One member of staff described the new managers as "absolutely gorgeous" and went on to say "It's so nice to come to work these days." Another member of staff told us "[Clinical manager's name] is up here all the time to support us. Every time someone is poorly she is here." A third staff member said "They're very approachable, if there's a problem they'll come straight out and sort it."

We were told by the staff that they felt that the management valued their opinions. Meetings had been held for health care assistant in August and November 2016, for nurses in July and November 2016, and for team leaders in July and November 2016. Members of staff said "I wouldn't want to work anywhere else."; "The atmosphere in here is lovely now."; "I love it here it's a positive place to work, we work as a team." On each floor the management had implemented a 'brainstorming' file. This was an opportunity for staff to say what was working well, what needed to be improved, and new ideas for the way forward. These files were checked by the manager weekly.

The home was divided into three units, one on each floor, and each of the units had a unit manager who was an experienced registered nurse. The unit managers were allocated two shifts a week for administration work, for example ensuring that care plans were up to date and supervising staff.

We asked if there were residents meetings and if anyone attended them. One person replied "We've had a residents meeting, the lady that has taken over has made such a difference." People thought their opinions

were listened to. A relative told us "They do listen, whether they can do anything about it is a different matter."

We saw that the manager had started reviewing all the policies and procedures in the home, many of which were out of date. Some had been rewritten and others had been reviewed and a plan was in place to make sure they were fit for purpose. A detailed improvement plan had been written which included the names of the staff members responsible for implementation and timescales for completion. We looked at the improvement plan and considered that it was achievable and measurable and addressed areas where improvements to the service were needed.

During our last inspection we found that the home's quality assurance tools were not fit for purpose and did not provide useful, evidence-based information about the quality of the service. The new management team had been developing a new quality assurance system and had started to implement this.

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 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 People's medicines were not always managed safely.