Aroma Care People Ltd

Aroma Care – Cotswold

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was completed on 18 and 20 December 2017 and 8 January 2018 and was announced. Aromacare - Cotswold is based in the Cotswolds and provides a service to the local rural area.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults.

The provider was given 48 hours' notice because the service provides a domiciliary care service; we needed to ensure we would be able to meet with people where they were receiving the service. At the time of the inspection, the service was supporting 44 people in their own homes.

Not everyone using Aromacare - Cotswold receives a regulated activity; CQC only inspects the service being received by people provided with the regulated activity of 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

We carried out this inspection as a social worker shared information with us in November 2017 which indicated potential concerns about the care being provided and the management of the service. This inspection also examined these concerns.

Aromacare - Cotswold is a newly registered service and this was their first inspection and rating. We rated the service as 'Requires Improvement'.

Aromacare - Cotswold registered with CQC in July 2017. The service had taken over people's care from another care provider at short notice. We found some areas that require improvement and discussed these with the director and registered manager of the service. They were already aware of some of these concerns and had drawn up a detailed improvement plan with timescales during our inspection to start addressing the concerns we found.

There was a registered manager in post at the service; 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was not always safe. People's care visits had not always taken place as planned and people had experienced late and missed visits. Individualised contingency plans had not always been noted in people's care plans to ensure consistent action would be taken to keep people safe when their staff were running late.

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. However, CQC had not always been notified of missed care visits which would require

action from the service to ensure people were protected and safeguarded from neglect. Criminal checks had been completed for all new employees however records of references and work history were not always completed appropriately to ensure all staff were suitable for their roles.

The service was not always effective. When people's care ran late people were not always supported to eat and drink at their planned times and in line with their preferences. We made a recommendation about individualised meal time support.

Training completed by staff included, first aid, safeguarding vulnerable adults, medication administration and moving and handling. Staff told us they had the training and skills they needed to meet people's needs. The service was adhering to the principles of the Mental Capacity Act 2005(MCA). Staff were receiving regular supervisions and attending team meetings.

Care and support plans were not always person centred. They had been updated and reviewed however important information was missing or not available to ensure staff would have all the information they needed to provide personalised care.

The service was not organised in a way that always promoted safe and quality care through effective monitoring systems. Some effective monitoring systems were in place but further systems and processes needed to be implemented and maintained in order to improve the standard and delivery of care which was being provided. People and their relatives were not always confident with the management of the service and told us they did not always feel like their concerns were listened to.

People were supported to access healthcare professionals when they became unwell.

We found four breaches of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

People could not always be assured that their care would be delivered as planned. Some care visits had been missed and staff were sometimes late for people's visits.

Staff understood their role and responsibilities to keep people safe from harm.

Risks were assessed and individual plans put in place to protect people from harm.

Improvements were needed to ensure when people missed their medicines this would be reported to the office so that prompt action could be taken to ensure people were safe.

Is the service effective?

Requires Improvement

People were cared for by staff who had received sufficient training to meet their individual needs.

People did not always receive support to eat and drink in line with their preferences.

Staff promoted and respected people's choices and decisions.

People were cared for by staff who felt supported by managers and senior staff.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect.

People were involved in planning their care and support.

People we spoke with told us staff were caring and kind.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care and support plans were not always detailed. Reviews had not ensured care plans were tailored to the individual to enable staff to carry out care in line with their preferences.

People and their relatives were not always confident they could raise concerns and that they would be listened to.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were some monitoring systems in place; however these were not always effective to identify shortfalls and drive improvements across the service.

The culture of the service had been one of uncertainty but this was steadily improving.

People and their relatives told us they were happy with the care they received however everyone we spoke to told us that improvements could be made in the timelines of people's care visits.

Aroma Care – Cotswold

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.

We carried out this inspection as a social worker shared information with us in November 2017 which indicated potential concerns about the care being provided and the management of the service. This inspection also examined these concerns.

Prior to the inspection we looked at information about the service including notifications and any other information received from other agencies. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

This inspection was completed on 18 and 20 December 2017 and 8 January 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection site visit activity started on 18 December 2017 and ended on 8 January 2018. It included looking at records, visiting people who use the service in their homes, talking with staff and phone calls and emails to relatives and health professionals. We visited the office location on 19 and 20 December 2017 and 8 January 2018 to see the registered manager and office staff; and to review care records and policies and procedures. The inspection was completed by two adult social care inspectors.

We spoke with the director and registered manager of the service and six members of care staff. We visited four people living in their own homes. We contacted nine relatives who gave us feedback on the service provided by Aromacare - Cotswold. We received feedback by email from four health and social care professionals who have regular contact with the provider.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

People and their relatives told us people's care visits did not always take place at the planned and agreed times. They stated at times staff had missed their visits, sometimes ran too late or too early and did not always stay for the allocated amount of time. They told us when Aromacare - Cotswold had first provided their care in April 2017 missed and late visits were very common; however things had improved since the provider had implemented an electronic monitoring system where care staff logged in an out of people's homes in real time. This had been introduced two months prior to the inspection.

We looked at records for six people during the previous four weeks and analysed the data provided. We found visits were often late and relatives confirmed this. However; the amount of missed calls had significantly improved since September 2017. For example, one person who had an agreed morning visit at 07.30am was not visited by care staff until at least 10am on many occasions. The relative of this person said, "They are consistently late, there are no real set times when staff arrive even though we have agreed visit times. They come as early as 6.00am and as late as 2.00pm and that's a long time with no food or drink". Another relative said, "Things have improved slightly, it was all over the place at the beginning. We have raised our concerns". One health professional said, "I have reports that carers are late for visits and I have had a few where visits have been missed altogether".

A number of people relied on staff to help them with their day to day living. Missed or late visits for some people increased the risk of them being left in the same position for long periods without pressure on their skin being relieved. Some people were at an increased risk of falls or injury if they tried to undertake tasks themselves which required assistance whilst waiting for staff to arrive. Other people might not have timely access to food or drink. The impact of care not being delivered on time or not at all had not been identified as a risk in people's assessments. We were told some people using the service lived with dementia and did not understand when the office called them to let them know their care will be late. Robust risk management plans had not been put in place to reduce the risk and potential harm to people if their care visits were not on time. The registered manager told us they had agreed contingency plans with people. However people, relatives and staff could not always describe what these arrangements were and they had not been noted in people's care plans to ensure they would be reviewed when people's needs changed

The provider told us they were aware of the concerns relating to missed and late visits. They were liaising with the local authority to ensure they were kept informed of any issues with people's care and were committed to improving timings of visits. They told us the rural location covered by the service brought specific challenges for example; limited mobile phone coverage made it difficult staff to inform the office if they were running late, travel distances between people's homes were significant and there were often traffic delays. A new electronic system was being introduced to further improve the monitoring of people's care visits and to support the registered manager to plan the deployment of staff. Although the provider was taking action to address the timeliness of care visits at the time of our inspection people did not always receive their care as planned.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All recruitment checks were not always completed thoroughly to ensure new employees would be suitable for the role. Records showed staff had a Disclosure and Barring Service (DBS) check in place. A DBS check allows employers to see if an applicant has a police record for any convictions that may prevent them from working with vulnerable people. We looked at records for six staff which evidenced they had a DBS check in place however; one staff members DBS was recorded in a different name than what was recorded on other documentation. The registered manager had not recorded how they had assured themselves this was the same staff member. Records of references were not always completed appropriately and applicant's recorded work history was not always complete with explanations of employment gaps. For example, one staff member had a reference from a family member who was their next of kin. Another staff member had a reference from a friend and a previous employer however; these were written in similar handwriting and on the same day. We could not be assured that these references had been verified for legitimacy and that safer recruitment had taken place.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

Staff completed a six month probationary period where the provider checked if they were performing to a suitable standard. This process enabled the registered manager to come to a conclusion on whether the member of staff was suitable to work with people. The provider had a disciplinary procedure and other policies relating to staff employment.

People received their medicines by staff trained in the administration of medicines. Staff had completed training to administer medicines and had their competency checked by the registered manager to ensure they did it appropriately in accordance with the provider's policy. There was a procedure for supporting people to take their medicine safely. This ensured staff would promptly report any medicine errors including when people had missed their medicines to the office so that action could be taken to ensure people were safe. We found the medicine error reporting system was not always effective. For example, one person's medication administration records (MAR) showed they had missed their medicine two days before our inspection. This had not been communicated to the office so that action could be taken to determine if this was a recording error or whether the person had missed their medicine. A new electronic medicine administration record was being introduced in January 2018 which would enable the provider to monitor people's medicine in real time.

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. Policies and procedures were available to everyone who used the service. The registered manager and staff recognised their responsibilities and, duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. There had been one incident in September 2017 where care staff had missed three consecutive visits to one person. These had not been reported to the service. This meant the person had not been given personal care, food or drinks for 24 hours. The registered manager had investigated this concern when made aware by relatives of the person and told us action had been taken to address the staff's misconduct through Aromacare – Cotswold's disciplinary procedure and lessons had been learnt regarding communication, ensuring staff completed the electronic call log as well as office staff taking action when visits are not being logged.

However, CQC had not always been notified of missed care visits which would require action from the service to ensure people were protected and safeguarded from neglect. We had consequently been unaware

of the number and type of incidents taking place. Where information is not appropriately shared with us, as is legally required, we are unable to sufficiently monitor services to ensure all necessary steps are taken to keep people safe.

This is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

People told us they felt safe with the care staff. People were supported to take risks to retain their independence; these protected people but enabled them to maintain their freedom. We saw individual risk assessments in people's care and support plans such as; falls, choking and moving and handling safety. The risk assessments we saw had been kept up to date however; these were brief and although they had been reviewed regularly but did not always contain relevant information. For example; one person's risk assessment did not contain information about a medical condition they had and how staff should support them with regard to a specific aid that was required. These were currently being changed to a new format so that they were more people centred and less generic to ensure people's risks were more prominent. Staff told us they had access to risk assessments and ensured they followed the guidance in them.

Staff completed training in infection control and food hygiene. This meant they could make people food as required and understand the procedures in place for minimising the risk of infections. Staff told us they had received appropriate training in their induction and this was useful. Staff wore aprons whilst delivering care and hand gel was available for staff to use.

Requires Improvement

Is the service effective?

Our findings

When people's care visits had been late or missed they had not always receive the support they needed to eat and drink as planned. A relative said, "[The person] does eat at strange times. It just depends when they turn up". One health professional told us "The staff are lacking basic skills such as rotating food to ensure food with a short use by date are used first". One relative told us "Today was not good. The staff member who visited put [The person's] food in another room so they could not get to it". We saw it was not clearly recorded in this person's care plan what support they needed during meal times. The registered manager agreed that they had identified prior to our inspection that people's care records required more clarification in this area. A new electronic care planning system was being introduced in January 2018. People's care plans were being reviewed to ensure they accurately reflected their current nutrition and hydration needs including details about people's specific dietary requirements, preferences and any food allergies.

We recommend that the service seek advice and guidance from reputable source about current best practice in planning and supporting people's mealtimes in a community setting.

We viewed the training records for staff which confirmed staff received training on a range of subjects. Training completed by staff included, first aid, safeguarding vulnerable adults, medication administration and moving and handling. Staff told us they had the training and skills they needed to meet people's needs. Comments included: "The training we get is very good" and, "I've had all the training I need to do my job well". People and relatives we spoke to told us they felt staff required more training in areas. One relative said, "[The person] has had a medical procedure and requires support to manage their aftercare. I had to show one staff member what to do recently. I would be worried if I wasn't here when they arrive". The director told us they were aware further training and development was needed to ensure all staff would have the skills to support people's individual needs effectively. This included for example supporting people with stoma and catheter care. They were working with the local district nursing team as well as training providers to develop staff's knowledge and skills in these areas.

Supervisions were used to monitor and improve staff's performance. Supervisions are one to one meetings a staff member has with their supervisor. Staff said these meetings were useful and helped them provide care more effectively. They said their supervisors and senior managers were supportive. The provider also carried out spot checks on staff to ensure staff adhered to the provider's policies when delivering care. Spot checks are when a staff member's supervisor joins them when they are providing care to assess how effective they are. We saw records to show these checks were happening on a regular basis and the findings discussed with staff. This ensured staff had understood what they had learned and were able to apply their knowledge in practice whilst supporting people.

Newly appointed care staff underwent an induction period and told us they spent five days shadowing more experienced staff. Relatives confirmed that newer staff visited and observed care for a while before undertaking any personal care independently. Staff would be offered an annual appraisal when they have worked for the agency for a year and identify any professional development they might require.

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA). The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack capacity to make some decisions. Staff understood their responsibilities with respect to people's choices and could explain how they support people to make day to day decisions. Staff were clear when people had the capacity to make their own decisions, and respected those decisions. People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. We noted that capacity assessments had been completed and where required people had been supported with decisions. One person's care and support plan showed us they had been assessed and had capacity to make informed decisions about their care.

Staff knew people well and monitored their health on a daily basis. People were supported to access healthcare when needed. People and their relatives gave examples of when care staff had reported concerns to office staff and relevant appointments had been booked. There was evidence in people's care records that the service had corresponded with healthcare professionals such as district nurses and GP's when guidance about people's health needs were required. The registered manager was reviewing people's care plans to ensure sufficient information would be available to staff to identify if people's health was deteriorating. For example, when people required catheter or stoma care.

Good

Is the service caring?

Our findings

There were positive comments about the staff from people and relatives and health professionals. One person said, "I am very happy. They are all really caring". Another person said, "They treat me with respect and they look after me well". One relative said, "I am really happy, they care for [The person] so well, some carers are better than others but the carers we know well are really good". One health professional said, "The feedback is mixed, most people tell me that the majority of care staff are kind and caring''

A compliments file was kept at the agency offices which supported people's positive feedback. This file contained a great deal of positive feedback from people and their family and friends. Comments included; 'Thank you to all of those who cared for [The person] throughout their illness. We are immensely grateful for your support' and 'All [The person] wanted was the dignity of spending their last few weeks of their life in their own home. Through your help and support they had their wish'.

People were involved in discussions about their care. One person said, "They ask me questions and see if I want to change anything". One relative said, "They do involve us when we are here". One staff member told us, "I love my job, working with all my clients. They are lovely and we always include them when we visit and help them to smile".

We observed how people's confidentiality was maintained and sensitive information was securely stored away. For example, information in relation to clinical support needs and specialist diets was available for others to see, care records and medication records were securely stored away. This meant that all private and confidential and sensitive information was respected and preserved and was not unnecessarily being shared with others.

Staff we spoke with were familiar with the care needs of the people they were supporting. Staff could explain and describe specialist support needs which needed to be managed on a daily basis, staff were familiar with specific preferences people had and were able to discuss different likes and dislikes of some of the people who were living at the home. For example, one staff member was able to tell explain to us how one person did not like to receive care and support from a specific gender of carer.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care and support plan which gave some specific information about how they should be supported. However; peoples care plans were not consistently person centred and sufficiently detailed to ensure staff had all the information needed to meet people's needs effectively. Some people's support plans had old company names on and were not regularly updated or reviewed to ensure the information was up to date. Records did not always contain sufficient details of people's personal preferences and were not accurate. In people's care and support plans there was limited information about people's social, cultural, religious or spiritual needs or preferences. This meant that staff may not have important information about people which supports them to engage with people and build positive relationships.

It was clear some information had not been written for each individual person. One person's care plan who was a female stated 'He like to have the same carers most of the time' and 'He like to watch outside and leasing to radio'. Another care and support plan gave another person's name on two occasions. Another person's care records did not state that they preferred a female staff member for delivering their personal care. We spoke to the relative of this person who told us a male carer had been on that day and they felt this was unfair to the person. One relative told us their relative had been supported by Aromacare - Cotswold since July 2017 but there had never been a care plan within their home for staff to follow or use as guidance. The registered manager told us all of the care and support plans were due to be updated when a new system was being introduced soon after our inspection.

People told us care staff tried to ensure they spent time talking with them. However, several people and relatives commented that they were aware of the time pressures staff were under. One person said, "They do try and talk but they're often in a rush to get to the next person". One relative said, "They don't have much time to chat, they do everything they need to but are always rushing". We looked at staff rota's which did not give much travelling time between visits within the rural location of the service. One health professional told us ''I am regularly told they are rushed.'' We discussed this with the registered manager who told us they were continually trying to improve the rotas and visits being on time. They told us the new system that would commence in January 2018 would be beneficial

The above demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they did not always feel listened to when raising complaints or concerns. We looked at records which detailed a quality assurance system which people filled in about their care. These were mostly positive. However when speaking with people and their relatives they told us this was not always the case. One relative said, "I have explained I am not happy on many occasions but they don't always listen". Another relative said, "The carers are good, but communication between us and the office is poor. They don't always get back to you with answers". Another relative said, "[The person] came out of hospital recently so I spoke to the office. I explained which visits were required and the next morning no-one turned up. The information had not been communicated effectively. [The person] had no care".

Records showed where people and relatives had been able to make a formal complaint they reported action had been taken. The provider had recorded three formal complaints since their registration and we noted two of these had been dealt with and appropriate action taken such as using their disciplinary procedure for one staff member. One health professional told us, "I have had two cases recently both who have ceased with Aromacare - Cotswold as issues have not been resolved, despite being raised in meetings with Social Care, or direct contact with families".

We recommend the service seek advice and guidance from reputable sources about removing the barriers people, relatives and health professional's face when raising concerns about the service delivery.

Staff confirmed any changes to people's care were communicated in shift notes to ensure they were responding to people's current care and support needs. A communication record was available for each person supported by Aromacare - Cotswold and details of actions or comments were recorded. If staff had any concerns whilst supporting people, they would call the office or an on call manager if it was out of hours. One person said, "They do write in the book every time they are here". One staff member said, "We do ring, if we have mobile signal but communication can be difficult if we don't".

The service provided care for people at the end of their lives. Staff had received training in providing end of life care. When required, end of life care was provided professionally and in a person centred manner, taking into account the person's wishes. One staff member told us about one person who was receiving end of life care and was unable to talk. The staff member told us, "I decided to start singing and dancing, just to see if [The person] would smile which they did. This made them happy and their relatives so I continued this on every visit until they had passed away".

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they were generally happy with the care they received however everyone we spoke to told us that improvements could be made in areas such as; communication, timeliness, responding to concerns and documentation. People and relatives told us they required increased transparency from the provider regarding action taken to address their concerns. They felt they had to develop their confidence in the provider's ability to make improvements to the service.

The registered manager told us they had been working with the local authority since August 2017 as concerns had been raised with regard to the amount of late and missed visits and communication issues. Several meetings had taken place and some areas were improving. The local authority confirmed that the reliability of the service was improving when we spoke to them.

The service had some monitoring systems in place and the registered manager was responsible for regular audits of the service. This was positive and effective in some areas. For example, senior staff carried out spot checks to monitor staff's skills and staff felt fully supported through regular supervisions and team meetings. Audits had taken place in areas such as; communication books, staff training, care and support plans and risk assessments. However some quality monitoring arrangements required improvement to ensure that shortfalls would always be identified and rectified within a timescale that protected people from the risks of receiving unsafe care. For example, the service had not identified that their incident reporting system had not been effective in reporting that one person had missed their medicines. They had not identified that their recruitment policy had not been implemented appropriately and that notifications had not always been submitted to CQC as required.

An electronic system was in place to monitor whether people received their care visits on time and stayed for the full duration of the planned visit. However, this had not always been effective as it had not always been used by staff. The provider had identified that there were barriers to using this system and was reviewing how this could improve. For example, office staff now monitored the system throughout the day and contacted staff if they did not log on at the required time. However, at the time of our inspection the effectiveness of this system still needed to improve.

The above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, the provider's arrangements to address shortfalls were reactive to issues identified through external monitoring processes rather than proactive in identifying issues before they presented a risk to people using the service. The provider told us that they were aware that they had not been able to always complete their routine monitoring of the service as covering care visits had been their priority. They were motivated to improve the service and had a good understanding of the improvements that were required. During our inspection the provider had drafted a service improvement plan to address these issues and it was in an early stage of implementation. We were not therefore able to judge yet how well the improvement plan was driving improvement.

The provider had identified that their monitoring systems required improvement and had purchase an electronic system that would improve the monitoring of people's care plans, enable the auditing of people's medicine administration as well as analysis of accidents and incidents. Time was needed for these new systems to be implemented and evaluated before we could judge the effectiveness.

The service was still relatively new and people, relatives and staff told us the service did not operate effectively initially but initially but improvements were being made. The culture of the service had been one of uncertainty but this was steadily improving.

People, relatives and staff had the opportunity to feedback to the provider on the quality of care provided. Regular quality monitoring phone calls were completed with people. We saw these to be generally positive. These results did not reflect what people, relatives and professionals told us. We received comments about the service needing to improve before people could feel they received high quality care. These included the provider ensuring greater consistency of staff, not sending new staff without an introduction, minimising incidences of late visits and assuring all care visits were attended by care staff. Though these quality calls had been undertaken by the provider to gain people's satisfaction with the service, it had not been effective in identifying the concerns we found.

The provider told us they were aware that the feedback they received were not always reflective of people's experience of their care. They had instructed a consultant to gather people's views and were implementing their recommendations which included reviewing how people's feedback was to be sought.

Staff attended regular team meetings and briefings. A surgery for staff had been introduced for staff on a Wednesday afternoon between 13.00 and 15.00pm where staff could call in the office and discuss any concerns. Staff told us they felt listened to and their main concern was managing the time constraints with regard to visit times. The provider continued to recruit staff to increase the team's responsiveness when unplanned delays to people's care was to occur.

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
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Registered persons had not notified the Care Quality Commission of all incidents of potential abuse. Regulation 18(1) (2)(e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support plans were not always person centred or accurately reflected people's needs or choices. 9(1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to ensure areas for improvements would always be identified and addressed promptly.(17)(1)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered person did not have effective recruitment procedures in place. (19) (2)