Care Quality Commission

Jark Healthcare Limited

Jark Healthcare - Kings Lynn

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 May 2016 and was announced.

Jark Healthcare - King's Lynn operates from an office in the centre of the town and provides care and support to people living in their own homes. At the time of this inspection, there were 12 people receiving services.

There was no registered manager in post in day-to-day charge of the service as required by the provider's registration conditions. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. Although a manager remained registered on our database it was clear from discussions at the agency that the person had not fulfilled that role since April 2015. A new manager had been appointed and started work at the agency in February 2016 but was not yet registered.

People experienced a service that promoted their safety. They received assistance from sufficient numbers of staff to meet their needs and to keep them safe. There were robust recruitment processes in operation, which contributed to protecting people from the employment of staff who were unsuitable to work in care. Staff were aware of their obligations to report any concerns that people may be being abused. Risks to people were assessed and there was guidance for staff about how they should minimise these risks while they were delivering care.

Staff were trained to administer medicines safely but there were few people using the service for whom they needed to assume this responsibility. The way that the competence of staff to administer medicines safely was assessed needed improvement and the manager had plans to address this.

The service was not wholly effective. Some training identified as required as part of people's care packages had not been provided and some guidance from a health professional had not been properly incorporated into a plan of care. This had not had an adverse effect on anyone at the time of the inspection but presented a potential risk that people's complex health needs may not be fully met by competent staff.

People received support from staff who were polite, respectful and kind. Staff were aware of the importance of promoting people's privacy, dignity and their independence as far as practicable. Staff were aware of people's individual needs and preferences for the way they wanted their care to be delivered. Staff also understood the importance of seeking people's permission before delivering personal care.

People and their relatives were confident that, if they had any concerns or complaints, the management team would take these seriously and respond to them.

Almost all of the staff had joined the service recently so had only worked with the current manager who they felt was supportive. They were well-motivated and enthusiastic about their work. However, frequent changes in management and leadership over the last year compromised the ability of the service to properly and robustly monitor the quality of the service people received, taking into account people's views.

The provider had failed to comply with the rules about events they needed to tell us about by law and had failed to provide us with required information about the service. Inconsistent arrangements for leading the service during 2015 may have contributed to these failings. We have told the provider that they must improve in this area.

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?

Good

The service was safe.

Recruitment processes were robust and staff understood the importance of protecting people from abuse.

Risks to people's safety were assessed with guidance for staff about how to minimise these.

There were enough staff to meet people's needs safely.

Where staff were involved in assisting people with medicines, they understood the importance of doing this as safely as possible.

Is the service effective?

Requires Improvement

The service was not consistently effective.

There was a potential risk that people would not receive prompt support to maintain good health.

People could not be sure that staff had received and understood all their training and so were competent to meet people's needs.

Staff sought people's consent to deliver care.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate.

Staff respected and promoted people's privacy, dignity and independence.

Is the service responsive?

Good

The service was responsive.

Staff understood people's individual needs and preferences and

what was important to them.

People and their relatives were confident that any concerns or complaints they had would be properly addressed.

Is the service well-led?

The service was not consistently well-led.

The provider had not told us about events happening within the service that were required to be notified.

The service was without a registered manager in day to day charge of the service and had been so for over a year. Recent changes in the management structure had not had time to embed to demonstrate consistent leadership but some improvements were being made.

People and staff were confident that the manager would listen to their views about the service.

Care Quality Commission

Jark Healthcare - Kings Lynn

Detailed findings

Background to this inspection

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

This inspection took place on 5 May 2016 and was announced. It was completed by one inspector. The provider was given 48 hours' notice because the location provides a domiciliary care service. We also gathered additional information on 11 May 2016, after the office visit.

Before we visited the service we reviewed the information we held about it. The information included notifications about events taking place within the service and which the provider is required to tell us about by law. We also received information from the local authority's quality assurance team about their views regarding the quality and safety of the service.

In March 2016, we also asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During the inspection we spoke with the Nominated Individual who represents the registered provider. We also spoke with the manager and four other members of staff, including the training officer. We spoke with two people who used the service and relatives of two others where people found it difficult to communicate using the telephone.

We reviewed records associated with the care of four people using the service. We also looked at the training programme for staff and recruitment records for two staff recently appointed. We reviewed other records

available in connection with the quality and safety of the service.

Good

Is the service safe?

Our findings

The current systems in place contributed to protecting people from the risk of abuse.

People or their family members told us they had no concerns about the way staff behaved towards them. They said they felt safe using the service. For example, one person told us, "I haven't had any concerns." A relative told us, "It's safe in all the process."

We found that the staff handbook contained clear guidance for staff about what forms abuse may take and what signs people may show that they had been harmed in some way. People's right not to be discriminated against was included in the handbook in relation to equal opportunities.

The handbook was under review and we found that the current version was not specific about the obligation of staff to report suspected abuse. However, staff spoken with confirmed that they had training to enable them to recognise and respond to abuse. They were clear about the signs people may show that would indicate suspicions they had experienced ill-treatment. Staff were also clear that they had a duty to report any such safeguarding concerns and were confident the manager would take action. One staff member also identified the Care Quality Commission as an organisation with whom they would be able to raise concerns about poor or unsafe practice by staff if they felt this was necessary.

Risks to people's safety were assessed, with guidance for staff about how these were to be managed and minimised.

People told us that the agency manager had visited them before they started to receive services to assess their needs and to ensure staff could meet them safely. One relative told us how staff were aware that a person's ability to mobilise well and safely may vary and took this into account in the way they supported the person.

In September 2015, the local authority's quality assurance officer and safeguarding team expressed concerns about the way risks to people were assessed and managed, including risks posed by poor mobility. There was a lack of evidence showing when pieces of equipment used by staff within people's own homes had been tested. This presented a risk to both people and staff if they were using equipment that was poorly maintained. The quality assurance officer's report also identified a lack of detail about hazards for people's home environment which could place them or staff at risk.

At our inspection we found that there had been improvements in the way that hazards were identified and risks assessed so that they could be managed. This included the risks associated with falls and poor mobility. Staff told us that they felt there was enough information within people's plans of care to understand how to support people safely. They also said that they had training in the use of equipment to support people to move and transfer safely. This was confirmed by training records. Care records also showed that equipment people used had been tested to ensure it was safe. The manager had ensured that a concern about damage to a sling used with mobility equipment had been taken up with the person and

their occupational therapist and addressed promptly to keep the person safe from harm.

There were enough staff to support people safely and meet their needs.

People using the service told us that they had never experienced any missed calls. One person said, "They [staff] are always pretty much on time. They don't have to scrap and tear about." One relative commented, "Another thing I like is that within five minutes or so of their scheduled time they [staff] are always here. They always stay the required time." They added that the vast majority of the time staff arrived promptly for their visits.

Staff said that they thought there were sufficient numbers of them to meet people's needs and not to be rushed when they were completing care visits. They said that they were given sufficient time to travel between people's homes when they were on their 'rounds' and did not feel pressured to clip visits short. Our discussions with the manager showed that they were aware of the importance of balancing staff recruitment with increasing the numbers of people using the service. They aimed to ensure that there were sufficient staff properly in post and trained in safe working practices, before taking on additional business. This contributed to minimising the risk of people having missed or rushed visits.

Recruitment practices contributed to promoting people's safety and protecting them against the employment of staff who were unsuitable to work in care.

In September 2015, the local authority's quality assurance team and safeguarding team found that there were shortfalls in recruitment practices. This included identifying gaps in employment histories and in ensuring references were always sought from appropriate sources.

We found that improvements had been made. The records for staff recently appointed were clear and complete. The checklist within recruitment files confirmed that the required checks were made before staff were confirmed in post. The manager told us how they were intending to review the interview process so that there were always two staff from the office participating in interview panels. They were aware of the importance of ensuring fair principles and processes were followed.

One staff member told us how they had been allowed to start their induction training while some checks were still being made. They went on to tell us they had not been allowed to deliver care to people until all the relevant information had been received by the manager. This included completing an enhanced check to ensure applicants were not barred from working in care services.

There was limited involvement of staff in supporting people with their medicines but from conversation with staff, we were satisfied that they would know how to do this safely.

None of the four people whose views we gathered, or from family members, said they needed support with their medicines. Staff told us that they felt they had sufficient training and guidance to enable them to administer medicines safely. One staff member did say they were involved in the administration of medicines under supervision from a colleague with more experience in care. They were able to describe to us the checks that they made when they were preparing to assist a person with their medicines, so that this would be done safely.

The handbook given to each staff member set out the different types of support people may require with medicines, what they needed to check and how to support or prompt people. The manager recognised that they had not yet completed practical assessments of the competence of staff to support people safely with

their medicines. They told us they intended to address this.

Requires Improvement

Is the service effective?

Our findings

There was a potential risk that support to people to maintain good health would not always be delivered promptly.

We noted that staff provided care for someone who had support from a family member who was generally available to assist and advise. However, we found that advice from a nurse specialist about one person's medical condition had not been clearly incorporated into guidance for staff about their care. The lack of consistency and clarity in the agency's care plan guidance for staff presented a risk that staff would not be aware of the need to intervene promptly in the event that the person became unwell.

Responsibility for supporting people to have access to healthcare services was not part of the current care packages the agency delivered.

People currently using the service lived with family members who took responsibility for ensuring advice about their health was sought when it was needed. This was not part of what was expected of staff. Our discussions showed that staff recognised the importance of reporting any concerns about people's health to family members and the manager if appropriate, so that issues were followed up. They also showed that they were aware how people's health may fluctuate and that sometimes they needed to be flexible in how they offered support if people were feeling tired or unwell.

There was a potential risk that people would not receive support from staff who were fully competent.

We noted that a care plan, devised in February 2016, indicated that staff would need training from a district nurse to administer food, fluids and medicines via a percutaneous endoscopic gastrostomy (PEG) tube. This is a tube inserted through the stomach wall and generally used where people have difficulties with swallowing or choking. Staff had not yet provided this support. However, the person's care plan clearly stated that they would need to be able to do so in holiday periods when the person's care arrangements may change. At the time of our inspection, 11 weeks after the person started to receive the service, staff had not had the training identified as necessary. We raised this with the manager who took action to arrange it for relevant staff.

Staff spoken with said they had not yet had supervision, including during their probationary period after starting work with the agency. This is when additional support, particularly of staff new to care, may be needed to ensure they are able to meet the provider's expected standards of conduct. Supervision is needed so that staff have the opportunity to discuss their work, performance and development needs. The manager recognised that there had been a shortfall in ensuring there was a regular programme of supervision and spot checks on the competency of staff. They had started to address this and an ongoing programme of supervisions for the staff was in place.

The provider's training officer outlined the training provided. The induction training showed a mixture of face-to-face training and e-learning using the computer. This was confirmed by staff spoken with. The

training officer told us that e-learning was under review. The training officer had recognised that the existing e-learning programme allowed staff multiple opportunities to choose the right answer to questions from a selection of responses. This way of learning was therefore under review as the training officer felt it was not a robust way of assessing the competence of staff and their understanding of the training content.

People told us that they felt staff were competent to support them in the way they needed. A relative told us that a newer member of staff was, "…not quite as efficient…" as a more experienced colleague but felt that the staff member was learning and, "…will get there." They recognised that new staff, "…all need to start somewhere."

Staff told us that they had access to induction training and training updates. They felt that this equipped them to meet people's needs competently. One staff member told us that they felt the face-to-face induction training they had received was very professional. They also commented that the staff handbook was very useful and provided a lot of background information for them to refer to. Another staff member told us that they had been impressed with the training they had received. Staff confirmed that they had the opportunity to complete 'shadow' shifts so that they could learn about people's needs.

Staff spoken with told us that they felt well supported by the manager and able to approach her with any issues they were unsure of, or if they needed additional advice.

The manager said that the monitoring system for recording training was under review so that training could be updated when it was needed. Most staff were new in post and so the need for regular updates to training that would expire after a year, had not yet arisen.

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

Staff sought people's consent before delivering care.

People using the service told us that, "They ask what I want done." They went on to say that staff asked whether there was anything else that needed doing before they finished their visits. Relatives also told us that staff spoke with their family members, explaining what they needed to do and checking whether they could assist.

Staff understood the importance of seeking consent from people before they started to deliver care to individuals. They confirmed that they had training to help them understand their responsibilities in this area. Our discussions with staff showed that they were aware of the need to check with people about the care they were delivering. They were able to give us examples of how consent was sought before they delivered personal care or assisted people. They told us that they were not supporting anyone at this time who was not able to give consent to their care.

There was guidance about seeking consent available to staff in the handbook with which they had been issued. We found that this clearly set out the importance of obtaining permission from people before they delivered care. It also reminded staff that they needed to offer explanations to people about the care they were seeking to deliver. It was clear that staff should contact the manager if they had concerns about people refusing care that was considered essential for their health and well-being.

People and their relatives, told us that their care packages did not require staff to prepare meals and drinks and to regularly monitor their risk of not eating or drinking enough. However, the care plan for one of these people showed that staff sometimes needed to prompt or assist the person to eat their meals and reflected the importance of good nutrition. Staff responsible for meeting this care package showed that they were aware of the need to be flexible in ensuring the person had enough to eat. Staff also told us that they would always respond to people's requests for a drink and make them available to people.

Good

Is the service caring?

Our findings

People were supported by staff who had developed positive and caring relationships with them.

People told us that they felt well cared for by staff. For example, one person told us, "They [staff] have got used to how I like things to be done." They told us they would rate the service as ten out of ten for the way they were supported and, "Staff don't rush you. They're quite relaxed and they do it at our pace." They felt that staff always had time for them. A relative commented to us that, when a staff member had been unavoidably delayed in traffic, someone from the office had contacted them so they and their family member would not worry about missing a visit. Everyone spoken with felt that staff would do what they could to assist, did not 'cut corners' and always checked if there was anything else they could do before they finished their visits.

A relative told us how they had anticipated that their family member would find it difficult to accept care from the agency. They went on to tell us how this had not been the case. They said that they generally had the same staff members so their family member had got to know who they were and developed confidence in them. They told us the person, "…is happy with them, accepting and fine because [person] likes the staff."

Another relative told us how staff were friendly and that their family member received care from a generally consistent group of staff. They told us that this meant staff had got to know how the person wanted to be supported and had built up a good relationship with them. They appreciated that sometimes they would get different staff attending to calls as a result of illness or holidays, but said that changes were rare. They told us that, although they did not receive a copy of the proposed rota for staff who would be completing calls, they were informed who would be attending the next visit.

Two members of staff told us that the good thing about the agency was that they, "…care about people."

People were supported to express their views about their care and how they wanted this to be delivered.

People and their relatives told us they were involved in discussions about care needs and how they wanted these to be met. A relative, who had been their family member's primary carer, told us how staff had listened to them and their experiences. They said that staff took this into account when they were supporting the person so that this was a comfortable and familiar routine. In the care records we reviewed we could see that most people had been involved in discussions about their care and had signed their care records to confirm this.

People were treated with respect for their privacy, dignity and independence.

Two people using the service told us that staff were always polite and kind to them. Another person's relative confirmed this and gave us examples of how staff promoted the person's dignity when they assisted with personal care. They went on to tell us how a staff member, although relatively new in post, had

recognised when their family member was tired and needed a little more time, reassurance and assistance. They reflected that staff supported people to do as much as they could for themselves.

We spoke with staff about the needs of those people they supported. Their responses showed that they appreciated the importance of people's dignity and independence. A staff member commented particularly how they valued the section in their handbook which explained in detail how they should support people with bathing or showering. We checked the guidance in the handbook. This focused on not only people's safety, but how staff could assist them with respect for their dignity and personal feelings. It also set out that bathing or showering should be a pleasant and relaxing experience for people.

People's care records were clear about how staff were expected to encourage people to maintain their independence and to encourage them to do what they could for themselves.

Good

Is the service responsive?

Our findings

People received care that was personalised and reflected their individual needs.

People told us that, before they started using the agency, the manager had visited to talk to them to assess their needs. People and their relatives were confident that staff would respond to any changes. They all told us that they had not been using the agency long enough to expect to be involved in any reviews of their care. However, one relative described to us how changes in their family member's health had meant they needed to change the arrangements for care visits. They said that the agency was responsive and flexible to such requests.

We noted that people's care records documented the assessments of their needs. These were then used to develop plans of care to guide staff about what was required at each visit. However, we found that the guidance given for staff about people's needs was not always focused on the findings of individual assessments. For example, we found that two people, with differing assessments of continence and personal hygiene needs, had identical care plans. These were not focused on the needs of each individual and how staff were expected to meet their specific needs.

Because of this we spoke with two of the staff who were engaged in delivering care for the people concerned. They were able to tell us about the people's individual needs and preferences, how these differed and what was important to each person. They were also able to tell us about people's backgrounds and histories. Staff confirmed that they were always able to seek advice from the manager if they felt that people's needs had changed or were having difficulty meeting them for any reason.

Support with people's social and recreational needs was not part of the care that staff were expected to deliver to the majority of those currently using the service. However, one person did tell us how the agency manager was supporting them with social services to try and access additional staff support so their family member could go out into the local community.

People and their relatives were confident that they would be able to raise a complaint with the agency manager and have it addressed properly. Everyone spoken with told us that they had not needed to raise any concerns since starting to use the service. For example, one person said, "I've been with them for two months and haven't had any concerns in that time." A relative told us, "I've got no complaints at all." However, they knew that there was information about how to complain in their family member's file.

We reviewed the record of complaints received. This included a high volume of complaints relating to the part of the office which acted as an employment agency. There were no complaints about people receiving services in their own homes since the agency had re-started contracting to provide this. We suggested to the manager that it would be easier and more transparent, in showing how complaints were dealt with and learnt from, if there was a separate and distinct record for people receiving care in their own homes directly from the agency.

There was clear guidance for staff in the handbook, setting out their obligations to pass on any comments or complaints to their manager.

Requires Improvement

Is the service well-led?

Our findings

The service could not demonstrate stable, consistent and appropriate management and leadership.

The provider's compliance officer was also the Nominated Individual (NI) representing the registered persons to the Care Quality Commission (CQC). The NI told us that the service had been 'dormant' for a period of time during 2015. This meant that the location had not been delivering any personal care to people in their own homes. The provider had failed to tell CQC that the service had stopped providing services and what period of time this covered.

The provider had also failed to keep CQC up to date and informed about changes and events taking place in the service. In March 2015, the provider had notified CQC of the registered manager's absence which started on 16 February 2015. The provider had not told CQC that this absence had continued and that the registered manager had left the service in April 2015.

These issues were breaches of Regulation 15 of the CQC (Registration) Regulations 2009.

In September 2015 we were made aware by the safeguarding team of allegations of potential neglect and poor care to someone receiving services from the agency. The safeguarding practitioner followed this up with the agency. However, the provider failed to notify us of this alleged abuse.

This was a breach of Regulation 18 of the CQC (Registration) Regulations 2009.

The provider had given us information that their preferred communication method with CQC was that this was 'on line' rather than by paper correspondence. The provider had failed to keep the location's contact details and e-mail address up to date. This meant that they had placed themselves in the position where they failed to complete the required Provider Information Return for the service.

The NI undertook to notify us of the change of e-mail address for the office location promptly, so that the location records logged with CQC could be updated. These details are also expected, where there is a location e-mail, to be included in the provider's Statement of Purpose, setting out the organisation's structure and what they do.

In the absence of a registered manager, since February 2015, management arrangements had been unstable and inconsistent. For over a year, since April 2015, when the former registered manager left the organisation after a period of absence, there was no registered manager in post. The provider had not abided by the condition on their registration that they must have a registered manager for this location. A manager appointed in 2015 had not completed registration with CQC as required and had subsequently left the service. The current manager, appointed in February 2016, said that they intended to register with us.

The NI who had agreed to oversee the service in the absence of a registered manager gave us examples of previous difficulties within the management structure. They told us they were excluded from discussions

with the council's quality assurance team and safeguarding practitioners. This meant that the service was not properly overseen by the provider's agreed representative, the NI.

During 2015, the provider's quality assurance systems were insufficiently robust to proactively identify and address concerns for the quality and safety of the service. Shortfalls were identified in an audit completed by the council's quality assurance officer and safeguarding team in September 2015. There were concerns about recruitment records. The deficits recorded recorded in their report showed that the provider was not operating robust recruitment practices .

The council and safeguarding team's audit had also identified shortfalls in the way that risks to people were assessed and the way the care was planned to meet people's assessed needs. They identified concerns for the way that staff were supported, supervised and their competence assessed. One of the provider's directors contacted us in October 2015 to tell us they were working with the council's quality assurance team and safeguarding team members to improve. They told us that they would update CQC regularly regarding their action plan but this did not happen.

At this inspection we found that improvements had been made. There was a proper checklist for recruitment and this was being used effectively to ensure the required checks were made before staff started work with people. We noted, in discussions with the current manager, that there were plans to improve the process for interviewing applicants so that this was more objective and consistent.

However, current systems in place were not yet fully effective at assessing, monitoring and mitigating risks of people receiving poor quality care. Further work was needed to ensure processes were robust in identifying and driving any improvements needed.

Some staff had received spot checks on the way that they completed visits, before being 'signed off' as competent to deliver care. The current manager, in post since February 2016, was aware that this needed to improve. They particularly highlighted that checks on the competence of staff to administer medicines had not been completed. Medication administration record (MAR) charts had not yet been reviewed and audited. They told us they had plans to do this and that they were awaiting recently completed MAR charts being delivered to the office.

We identified concerns that some records were not appropriately audited to ensure that they were accurate in the way they reflected people's specific needs. For example, we found that two people of opposite sexes had identical information within their care plans about the way their personal hygiene needs should be met. We pointed this out to the manager who agreed this was likely to be an error in the way information had been typed up into the records on computer. They undertook to put this right.

We found that there were periodic checks on the daily records that staff completed about the care they delivered. This contributed to ensuring they were accurate, clear and appropriate so that shortfalls in expected standards could be identified and addressed.

People felt that their views were listened to and staff said that they could always seek advice and support from the current manager.

People using the service, or their family members, were not all able to confirm they had been formally consulted for their views about the quality of the service they received. However, most of them told us that the manager telephoned them from time to time, to make sure that they were happy with the service they received. Some told us that the manager had been out to see them and had taken part in delivering their

care on occasion. They told us they knew how to contact the office and would do so if they needed to make changes, suggestions or ask for advice. Staff also told us that the manager was approachable.

We acknowledged that the majority of people using the service were new to it, as were the majority of staff. The NI and current manager told us how they were planning to develop a formal system for ensuring that people, staff and other interested parties were able to express their views about the quality of the service and what they would like to see improved.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change The registered persons had failed to notify the Care Quality Commission when the former registered manager had ceased to work for the organisation and so was no longer managing the regulated activity of personal care. They had also failed to tell us that, for a period of time, the provider as 'registered persons' had not carried on the regulated activity of personal care and that it had been dormant. Regulation 15 (1)(b)

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to notify the Care Quality Commission of an allegation of abuse taking place within the service. Regulation 18(1), (2)(e)