Primrose Lodge Ltd

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Inspection report

Primrose Lodge Ltd
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was carried out on 11, 13 and 15 July 2015 and was unannounced.

Primrose Lodge provides accommodation and personal care for up to 21 older people including people who stay for a short stay, respite visit. It does not provide Nursing care. At the time of our Inspection there were14 people living at Primrose Lodge.

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

This is the first inspection of Primrose Lodge since the provider was reregistered on 16 March 2015 following a change to the name of the provider.

Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on

Summary of findings

what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection no applications had been made to the local authority in relation to people who lived at the service. Although the registered manager told us that at least three people were being deprived of their liberty. Staff were unaware of their responsibility in relation to MCA and DoLS.

We saw that people living at the home did not always get their needs met in a timely way. We saw that care and support focused on completing tasks rather than people's individual needs and preferences. Staff were required to assist people with personal care and support whilst also completing other 'tasks' such as cooking, laundry and cleaning. Staff could not always tell us what people's individuals care needs were. For example staff were unable to tell us how people were supported to manage their continence.

Although the storage and recording of medicines were managed safely we saw staff did not wear gloves or wash their hands when administering medicines to people. Staff told us that the manager observed their practice but we did not see competency checks recorded.

We found that staff knowledge varied and in some cases staff were unable to demonstrate sufficient knowledge of how to manage peoples care safely. Most staff had supervision with their line manager but the meetings were intermittent and we found gaps where people had not received supervision. For example a person had returned to work following a period of absence and had not yet had supervision with their line manager to bring them up to speed with current events.

Care plans and risk assessments were not focused on people's individual needs and preferences with many 'tick box' answers. There was little evidence of people or their relatives being involved, and staff were unaware of people's individual needs or how to manage them effectively.

People's nutritional needs were not always met, and food and fluid intake not managed effectively.

The management in the home was ineffective and many of the areas of concern that we found had not been picked up by the provider's monitoring systems. There were no action improvement plans in place to demonstrate areas for improvement were being managed.

At this inspection we found the service to be in breach of regulations 9, 10, 12, 13, 14, 17 and 18 of the Health and Social care Act 2008 (Regulated activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe."

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

People were not supported to ensure their needs were met safely.

There were insufficient members of staff on duty to meet people's needs safely.

Risks were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff did not have their competency assessed.

People were not consistently supported to eat and drink sufficient amounts to help them maintain a healthy balanced diet.

Consent was not consistently reviewed and recorded.

People were not supported appropriately in regards to their ability to make decisions. No MCA/DoLs applications had been made.

People were not consistently supported with healthcare needs.

Is the service caring?

Inadequate

The service was not caring.

Staff were task driven and did not demonstrate 'personalised caring' relationships with people.

People were treated with kindness but their privacy and dignity was not promoted.

People who lived at the home and their relatives were not consistently involved in the planning and reviewing of their care.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care that was responsive to their needs. Care plans and risk assessments were generic.

People were not supported to pursue hobbies or interests and 'activities' were provided intermittently when staff were available.

People knew how to make a complaint, however there was little evidence of learning from feedback.

Is the service well-led?

Inadequate

The systems in place to monitor, identify and manage the quality of the service had not identified issues found on our inspection.

Summary of findings

The service did not deliver good quality care and did not demonstrate an open and transparent culture.

Primrose Lodge Ltd

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This visit took place on 11, 13 and 15 July 2015 and was carried out by one inspector. The visit was unannounced, and was in response to some concerning information we had received. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 4 people who lived at the service, 5 members of staff, the registered manager, deputy manager and admin manager, and one visiting relative. We received feedback from health and social care professionals. We viewed 5 people's support plans. We reviewed four staff files. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to health issues.

Inadequate

Is the service safe?

Our findings

Not all staff were able to describe how people were protected from avoidable harm or abuse. We saw that staff had received training in the safeguarding adults from abuse; however staff understanding and competencies were not always checked. Two staff were also not able to describe the procedure for recording and reporting abuse and did not mention the provider's whistleblowing policy when asked how they could elevate concerns relating to possible abuse.

People were not protected from avoidable harm and abuse because the systems in place to identify and report abuse were not managed effectively. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people's mattresses were soiled with urine and faeces and bed linen was old, worn out and discoloured. Bathrooms and toilets were not clean and in one bathroom the soap dispenser was not working and had a layer of fungus growing on the top of the liquid soap inside the dispenser. We spoke to the manager about this and the poor standards of hygiene throughout the home and they said it was the staff's responsibility to ensure the cleaning was done. The manager accepted that it was their responsibility to ensure the cleaning audits that were in place were effective and people were protected from the risk of infection.

Staff were unaware of the code of practice for health and social care on the prevention and control of infections and related guidance and of their responsibilities to maintain a clean and hygienic environment for people to live in. We saw the cleaning schedule which was a series of tick boxes. All the boxes had been ticked, however the tasks had not been completed. This lack of hygiene put people at risk of infection, and we could not be assured that people's individual personal care needs were being met effectively or safely.

We observed that the building was in a poor state or repair and the environment was not clean and well presented. We found that communal areas including corridors, stairwells, bathrooms and peoples bedrooms were not maintained or cleaned to an acceptable standard. For example paint was chipped off walls, there were marks along the walls, baths toilets and sinks were stained and soiled soap dispensers did not work. There was damp in two of the bedrooms, there was a large area of wet with fungus, and a smell of damp. Three people's beds and bed linen were soiled and had not been cleaned or maintained effectively. Carpets were frayed in places and a particular concern as they presented a trip hazard.

People were not protected from the risks and control of infections, including those that are healthcare associated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive appropriate care that met their individual needs. We saw that people were assisted around the availability of staff rather than people's needs. In the morning we saw people who were ready to get up and dressed but were having to wait for staff to come and assist them. For example, we saw one person sitting on the edge of their bed with a bowl of water waiting for staff to return to give them assistance to wash. We observed staff that were assisting the person doing other tasks and assisting other people during this time. We saw that some people waited for more than 25 minutes, before staff came back to complete their care. Although there were three staff on duty they had been assigned other tasks such as cleaning, making beds, doing the laundry and making people breakfast.. We observed a staff member giving out medicines, another was delivering breakfast. This meant that people were not always able to be assisted and or supported in a timely way.

We observed that staff were busy and had their 'allocation list'. Staff told us they were responsible for doing all the tasks associated with the person, including non- personal care tasks such as checking their room to make sure it had been cleaned and that their clothes had been put away in the wardrobe. However we found that people's rooms were not cleaned to a good standard and clothing was dishevelled in the bottom of the wardrobe, and not hung up. We asked staff about this and were told they had not got round to doing these tasks yet.

We saw people sitting in the lounge with no staff present. This was evident throughout the day of the inspection. Staff passed through on route to another part of the home, but people were alone for periods of 15-20 minutes. One person was agitated and was shouting. Other people in the lounge looked concerned by this, and some people starting

shouting back at the person. Staff were not present to support the person to determine the cause of their distress or to offer reassurance to others. People were left sitting in the same room whilst the behaviour continued.

There were not sufficient numbers of staff deployed in order to meet the requirements of people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that medicines were stored appropriately. The staff were preparing the medicines, then going to individuals bedrooms to administer and then coming back to the dining room to complete the medicines record. During this process they touched other surfaces including door handles, table tops and MAR charts and keys to reopen the medicines cabinet and then proceeded to prepare the next medicines without washing their hands. We observed that medicines were being transferred from a blister pack to a small pot. They pressed the tablets out of the blister pack into the pot and their hands were in contact with the blister pack and pot. We observed that on at least two occasions the person administering the medication were interrupted by staff, there was then a short delay in resuming the recording of the medication and this increased the risk of a recording error occurring.

We saw that, risk assessments were not personalised and did not inform staff about how to manage risks safely. For example we saw that a person had had multiple falls over a period of time but they had not been referred to the falls clinic or GP for on-going support and management. Their risk assessment had not been updated following their falls to inform staff how to mitigate or minimise the risk of them falling again. This meant that the person had not been protected against the risks of repeated falls and or injuries sustained as a result and had continued to have falls. The person had not been referred for professional intervention such as the GP or the falls clinic to investigate and or explore why they were falling so frequently or to establish if there was an underlying medical reason or a change in the person's health condition. We also saw that where risk assessments had been updated they did not always include changes to people's needs and circumstances.

People were not protected against assessed risks with regard to the health and safety of people and risks were not mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that people were weighed monthly. We saw that several people had lost weight over the preceding three to four months but on checking care plans this was not recorded in their risk assessments and no referrals had been made to the dietician or speech and language therapy team or (SALT) team. For example we found that a person had lost five kilos in three months and another person had lost four kilos in three months without further investigation. We saw that two people had gained in excess of five kilos in a four month period, and had also not been referred for dietary advice or further investigation. The provider had failed to respond appropriately to people's changing dietary needs.

The nutritional and hydration needs of people were not being met and action was not taken to address the concerns. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

We observed care being provided and staff interaction with people, and found that it was not always effective. For example a person who was presenting behaviour that challenged others was not supported appropriately. We observed that the person became agitated several times throughout the day. Staff did not have the appropriate understanding and skills to support and reassure the person or to engage with the person. We saw that staff had training but competency was not tested and staff were unable to demonstrate that they had an appropriate range of skills and abilities to support people appropriately. Some staff had received training for people with challenging behaviour, but refresher training was due this year. This meant that staff may not have had the most up to date knowledge, skills or experience to enable them to support people appropriately.

We saw that consent had been signed in people's care plans to say they agreed with the care plan. We saw that consent was not reviewed as part of the monthly reviews and staff could not tell us about how consent was obtained. When asked one staff member about how they sought people's consent to care and treatment and they told us "we know what help people need from the care plan". We asked about staff about their responsibilities under the MCA/DoLs provision, they were unable to describe their responsibilities and what the impact was for people who may be deprived of their liberty. Care plans lacked detailed information and therefore it was not always clear from reviewing records or speaking with staff, if people had fluctuating capacity or whether consent had been reviewed.

The manager told us that three people required DoLs assessments to make sure the restrictions placed on them were lawful. These had not been completed. There were no best interest decisions recorded in respect of these people's care and support plans. This meat that these people may be being deprived of their liberty unlawfully and no authorisations had been sought from the local authority. The manager told us these people were unable to leave the home unsupervised and were restricted from doing so by way of a key code on the front door.

The use of unauthorised restrictive practices was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that people were not always supported to eat and drink sufficient amounts. We saw that people did not all have water jugs or a glass in their bedroom at all times. Staff told us the water jugs are changed by the night staff and they "usually leave them a cup with water". However in at least four bedrooms people had no water available. These meant that if people required a drink and were unable to request it or get the attention of staff that they had no access to water.

Staff did not know how much fluid people were required to have, and told us 'we have to record what the people eat and drink'. We saw that three people were on food and fluid monitoring charts and these were kept in the office. However these were not completed accurately or monitored effectively. We noted that fluid charts were not totalled and there were no recommended fluid intakes recorded for the three people so staff would not have known if people were being supported to consume the appropriate amount. We observed one person in their bedroom with a bowl of cornflakes and a cup of tea, neither of which were being consumed. We then observed staff taking the cup and plate to the kitchen still almost full, however the fluid and food chart records indicated that the tea and cornflakes had been consumed and this was not the case. This meant that people may not have been receiving adequate quantities of food and fluid to sustain good health and reduce the risks of malnutrition and or dehydration.

We saw that menus were displayed in the dining room however there was no alternatives or choices listed for the main meal of the day. We spoke to staff who told us that if people did not want the 'chefs menu' they could have a 'fried egg'. We asked if this was the only alternative choice available and if it was displayed anywhere or how people were informed about 'food choices'. Staff and the manager told us people were offered choices. Staff told us it was recorded in the weekly menu book. We reviewed this for the previous five days to see what alternatives had been offered, but found that no alternatives recorded, other than on one day when three people had had 'fried egg'. Although people did not comment on the lack of choice their food preferences were not being met.

We also asked staff about the availability of healthy and nutritious snacks and were told they were available, people could ask for them and tea and coffee were provided mid-morning and mid- afternoon. However we did not see any

Inadequate

Is the service effective?

fresh fruit or other snacks. During the course of the morning we observed people being offered tea or coffee and biscuits. Later, after we had asked about the availability of snacks we heard people being offered a piece of fruit. We overheard a person saying "what's all this about, is it someone's birthday?" suggesting that this was not the usual routine. The person told us that they were not usually offered snacks.

People did not receive the appropriate support to ensure they were able to eat and drink sufficient amounts to maintain their health and wellbeing. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that people were supported with their health needs. We were told that the GP visits once a week and they can see them if required. If at other times they are unwell a GP is called and attends to see the person at the home. Staff also told us people could request to see other healthcare professionals including the chiropodists, dentist or opticians. However records seen did not always detail when people had requested to see healthcare professionals.

We saw that there were robust recruitment procedures in place. Staff were mostly supported through induction, training and supervision. However we found that there were gaps in training and in particular 'refresher training' and competencies were not always tested. For example a member of staff who had just returned to work after being off for a year had not yet had safeguarding training and had not yet had their competences checked to ensure they had the appropriate skills to safeguard people from harm.

We did not see staff engaging people in conversations. We observed staff asking 'closed questions' for example 'do you want tea or coffee' rather than asking what they would like to drink or 'do you want to sit here' rather than asking where they would like to sit. This approach did not encourage conversation. Staff did not always explain to people what they were about to do before supporting people. For example, we saw staff assisting people to the dining room for lunch. Staff approached people and assisted them to stand up and then informed them "we are going for lunch" without giving people any choice about whether they wanted to go to lunch or where they wanted to eat. We observed that staff did not speak with people when assisting them, often finishing a task with little or no interaction with the person, before moving on to the next task.

There were not sufficient numbers of staff deployed in order to meet the requirements of people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

The practices in the service did not ensure people's privacy and dignity was respected. For example people were left in the middle of having support with their personal care and had to wait for staff to return. In one case we saw that a person seated in the lounge whose clothing had not been adjusted to ensure their body parts were fully covered. This was undignified and disrespectful for them and also others.

Another person was in their bedroom partially dressed awaiting assistance from staff. The care staff had started to assist the person but were called away to assist with another task.

We observed that staff did not always respond to people in a kind and caring way. For example when a person was shouting in the dining room the response from staff was to tell them they were going to another room because they were annoying people. Staff also did not reassure other people in the dining room when they became worried and anxious as a result of this incident. This lack of positive interaction and support demonstrated that staff had a limited understanding of people's needs and what was required to reassure people and reduce their distress.

People did not receive support in a caring and compassionate way. For example people were not being supported to maintain their continence. Staff told us that most of the people used continence products. Care plans did not contain specific details about people's continence needs, to inform care staff how best to support people. Staff did not encourage people to use the toilet and two people told us "they wear a pad" and that staff do not assist them to go to the toilet. Assessments did not take into account people's specific continence needs and these were not managed in a caring and supportive to assist people to maintain their continence and promote their dignity.

People's religious, spiritual and cultural preferences were not recorded and staff did not know if people had any particular needs or wishes in this respect.

Care and support provided did not ensure people's dignity and privacy. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from records and from conversation with staff that people were not routinely involved in their care planning or reviews of care. People told us that they could not remember being involved in the planning of their care.

We asked people if they were given information about the service or involved in discussions about how the service is run. Two people told us they could not remember being involved in discussions. One person told us they attended a 'talk'. The manager told us this was a 'residents meeting' which were held quarterly. This demonstrated that the meetings were not an effective way of interacting with people who lived at the home, and that relevant information was not provided in a format that enabled people to understand the choices available to them. We saw no evidence of advocacy services being used or promoted at the service. We asked staff if anyone had an advocate and the staff did not know. People were not given information about having an advocate and therefore could not make an informed decision about whether or not they would have been an appropriate source of support for people living in the home.

We observed staff assisting people throughout the inspection. But did not observe positive caring and compassionate attitudes. Body language also was task driven for example staff did not bend to speak with people or make eye contact. On one occasion in the dining room staff were talking to each other while assisting people with eating their lunch. The person being assisted was not included in the conversation.

People were not involved, enabled and supported in making decisions about their care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Staff did not always know the people they were supporting well and could not demonstrate they had sufficient knowledge to meet people's needs in a caring and compassionate way. For example when asked about a specific question about a person's care, a staff member responded saying the person "is not allocated to me so I don't know".

We saw that care plans were mainly tick boxes which were not person centred and did not contain sufficient detail to inform staff how to provide care and support which was responsive to people's needs. There were no life histories or personal likes and dislikes. There was no evidence that people had been involved in care planning or had been asked about how they would like their care to be delivered. Staff confirmed that care plans and risk assessments were 'done' by the manager and people were not consulted or involved. The manager told us that relatives were asked to contribute to the review process but usually declined. This was not evident in the care records.

Staff did not know about people's preferences or life histories. Staff were unable to tell us what people's hobbies or interests were. We spoke to staff about the activities for the day and were told there are none at the weekend because it is family day and people have visitors. However not everyone had visitors and those people did not have any stimulation or social interaction.

People did not receive care that was responsive to their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a person lying in bed with their legs hanging over the side of the bed. The person heels and toes were red. We asked if the person was comfortable and they responded saying their heels were sore. We asked if they had spoken to staff about this, and they said they know, but have not done anything yet. "They are very busy; they have so much to do". The manager told us this had been a long standing condition and the person had been referred to see the GP. The manager told us the person was prescribed pain relief but often this was not effective. The manager told us a more in-depth review of all the persons health needs was being undertaken by the consultant, but did not have a specific timeline for when this may be completed.

We observed that a person stayed in their room most of the time and was at risk of being socially isolated. The person's records stated that they liked to stay in their room but there were no assessments in place relating to the possible impact of this. Staff told us that the person did not like them to go in their room, however we spoke to the person several times throughout the inspection and they told us that they were happy to talk with us. We also found that staff were not supporting the person to maintain their dignity or hygiene. The person had made some unusual lifestyle choices. They had also not been offered a referral to any health professional for assessment or advice about their specific needs. After bringing this to the manager's attention they agreed to follow it up without further delay.

Activities were not provided relevant to people's hobbies and interests . People told us they would like to go out more often, to the shops for example. One person told us they went for a walk a couple of weeks ago, but other than that had to "find their own interests to keep occupied". We saw from activity records that activities were limited, for example reading newspapers and watching TV. People and staff told us they only walked in the garden and were not supported to go out locally. People told us they would like to go out more often and would like to go to the Shops. None of the three people we spoke with had any links outside the home or had any community links or involvement.

People knew how to make a complaint if they needed to. We saw that two complaints had been made, investigated and concluded. However, there were no records to show how complaints had been used as an opportunity for learning or improvement. We spoke to the manager about what had been put in place as a result of feedback/ complaints but they were unable to tell us.

Inadequate

Is the service well-led?

Our findings

The service lacked leadership and the management practices used were ineffective. The management at the service did not have a clear vision for the service. Staff did not know about the values and direction of the organisation, so they were not promoted by staff. Staff were not aware of what the homes aims and objectives, or what the governance arrangements in the home were. Therefore the systems in place were not always effective in identifying concerns or improving the service.

Leadership in the home was not consistent and there was no clear direction or guidance for staff. No manager's worked at the weekend and there were no clear lines of accountability. For example when we arrived a senior care worker was in charge, however they did not provide management guidance or support as they were busy completing other tasks assigned to them. They did not intervene when staff support to individuals was not appropriate to meet their needs. This lack of management guidance and or support may have suggested that managers were not competent and did not have the necessary skills to support and or direct care staff. Furthermore they were unable to locate specific records. Staff told us that not all records such as staff files were available over the weekend and that the manager would have to provide them.

The care people received at the weekend was not of the same standard as people received during the week. Not only was there no management support available at the weekend but there was also no cleaning, laundry or kitchen staff. This meant that care staff had to cover these tasks despite there being no extra care staff available. The manager was unable to explain how they assessed that people required fewer hours of care and support at the weekend.

The provider did not carry out regular checks to ensure that the management team were carrying out their role to an acceptable standard or that the service was being delivered in accordance with their statement of purpose. For example, the statement of purpose stated the provider would "work in partnership with all service users and their relatives ……and ensure the preservation of their dignity, and ensure the freedom of choice and respect for their individual needs". However, we found that people were not involved in decisions about their care, their dignity was not promoted and staff were not aware of people's likes, dislikes and preferences.

There were audits in place but these were ineffective. For example, there was an audit to monitor the cleanliness of the home. However, when we pointed out to the manager the poor standards of hygiene and cleanliness the manager was unaware of these concerns and told us they thought they were "doing a good job". The audits had not identified the issues that we found during our inspection so had not led to appropriate standards of hygiene being maintained.

The monitoring of various aspects of the service was insufficient to improve the service. For example falls were not followed up or information about fall used to identify trends and so reduce the risks of further falls. There was no evidence of learning from events. None of the issues picked up at the inspection had been identified through the monitoring systems in the home. Information that was recorded was not reviewed or analysed to ensure the quality of the service provided.

We highlighted a number of concerns to the manager during our inspection. Although the manager responded and took action to address the concerns the issues had not been identified through the providers own monitoring systems. This means that had we not pointed the concerns out to the manager they would not have taken this action.

A quality survey was completed in November 2014 by people using the service but this had not been analysed or any learning or actions put in place. For example, people expressed a wish for better activities and to go out in the community but this had not been acted on. The service had not responded to feedback and had not improved the quality of this aspect of the service.

The provider did not have effective systems in place to monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.