Chilworth Care Ltd

Peel House Nursing Home

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this home on the 27 and 28 July 2016. Peel House provides accommodation for up to 52 people requiring nursing or personal care. The home was arranged on two floors with stair and lift access. There was a large communal lounge and dining room on the ground floor of the building and gardens to the front and rear of the property. At the time of our inspection 47 people were living at the home.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a lack of systems in place to effectively manage infection control and the risks this posed to people living at the home. There was a lack of personal protective equipment (PPE) in place within the home to protect people from the potential risk of the spread of infection.

Environmental risks to people were not managed well so as to protect and respect people's freedom of movement within the home. However, risks related to people's individual health needs were managed well by nursing staff.

Annual required training updates had not been completed by all staff which could prevent them from being able to carry out their roles effectively and in line with the latest guidance and best practice regimes. Staff demonstrated a lack of understanding regarding the principles of the Mental Capacity Act 2005. There was some understanding of the need to gain consent when caring for people. Whilst Deprivation of Liberty Safeguards (DoLS) applications had been completed fully, there was no management process in place to ensure that records were kept up-to-date and that applications had been returned, renewed or reviewed. This could mean that people's liberties were being restricted without formal authorisation having been granted.

The home was in a poor state of decoration with most areas; including people's bedrooms, requiring attention. The design of the home was not dementia friendly and did not support orientation for those with memory problems.

There was a lack of management systems in place to effectively audit the quality of service provision to identify areas for improvement.

Care workers did not always engage with people living at the home and people did not always have their privacy and dignity promoted and respected. People did feel able to contribute to discussions and decisions regarding their care and support.

There were few meaningful activities for people to participate in. Care plans were personalised and identified people's preferences and wishes. Care plans were reviewed regularly.

Medicines at the home were ordered, stored and recorded safely. Staff administering medicines had completed annual training updates. Safe recruitment practices were followed.

People were supported to maintain a balanced diet and sufficient fluid intake. They were able to access health care professionals if needed and were supported by staff to achieve this.

Staff were supported in their roles by regular supervision sessions and annual appraisals with their line managers.

There was a complaints procedure in place and relatives told us that any concerns or complaints they raised had been dealt with appropriately and in a timely manner.

There had been relatives, residents and staff meetings held. Relatives told us that they did not feel the meetings were of benefit as feedback given was not always acted upon sufficiently. People and staff told us that they felt they could raise issues with the registered manager and that they would be listened to and their concerns acted upon.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this 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

The service was not always safe.

There was a lack of effective systems in place in the management of infection control to ensure the safety and welfare of people.

Risks to people were not always managed in a way that protected and respected people's freedom. Risks to people's health needs were well managed.

The provider carried out recruitment checks to make sure workers were suitable for work in a care setting.

Medicines were stored, administered and recorded in a safe and effective manner.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received their annual mandatory training updates to enable them to carry out their roles effectively. Staff were supported by regular supervision.

Staff demonstrated a lack of knowledge in understanding the principles of the Mental Capacity Act 2005 and how to apply this in everyday practice. There was some understanding of gaining consent.

Deprivation of Liberty Safeguards (DoLS) applications had been made, but there was a lack of robust management systems regarding the process of ensuring records were up-to-date

The home was in a poor state of decoration and design, and not able to meet the needs of people effectively.

People were supported to maintain sufficient dietary and fluid intake and to access external health care professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People's independence, privacy and dignity was not always respected.

Care workers did not always engage or converse with people living at the home, preventing them from building a rapport with people.

People were able to contribute to decisions affecting their care and support.

People felt able to speak up about their care provision and felt that the registered manager would listen and act upon any concerns.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were few meaningful activities available for people to participate in.

Care plans reflected the identified needs of people and were personalised, taking into account individual preferences.

There was a complaints procedure in place, and complaints were dealt with in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a lack of management systems and processes in place to monitor and assess the quality of service provision.

Residents meetings had been held but not all relatives felt that actions as a result of feedback were dealt with sufficiently.

Staff felt able to raise concerns with the registered manager and that they would be listened to.

Peel House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 27 and 28 July 2016. It was an unannounced inspection. The inspection team consisted of an inspector, a specialist adviser in nursing, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of dementia care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. Prior to the inspection, the provider completed a provider information return. 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.

People who lived at Peel House were not always able to tell us about the care they received. We observed care and support being delivered by staff within the communal areas of the home. We spoke with seven people who lived at the home and four visiting relatives, to obtain their views of the home and the care provided. We spoke with eleven members of staff including; the registered manager, training co-ordinator, nursing staff, a senior care worker, care workers, an activities co-ordinator, kitchen and domestic staff. We spoke with one external healthcare professional following our inspection who supported people living at the home.

We reviewed five care plans during our inspection and a range of records relating to the management of the service. These included; complaints and compliments, accidents and incidents, quality assurance documents and a selection of policies and procedures. We also looked at recruitment, training and supervision records for five staff members.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in the home. One person told us he liked being at the nursing home and felt safe. A relative said, "My [relative] is safe because she is well looked after, is well fed, and gets regular showers. She can't do much for herself but she does walk around a lot. I take her outside if it is fine."

There was a lack of infection control measures in place within the home to ensure the safety and welfare of people. Standards of cleanliness were generally poor and there were odours present throughout the home. In the ground floor toilet and the first floor shower room the soap and hand gel dispensers were empty on both days of our inspection. Outside the first floor shower room there was a large stain on the carpeting and wall that appeared to be bodily fluids. It was apparent that it had been there for some time. In one of the bedrooms the waste disposal bin was overflowing with used gloves and the box for staff to obtain new gloves to use when providing personal care was empty. A member of staff was witnessed opening the door to a person's bedroom where they had been providing personal care; they were wearing gloves but no apron to prevent the potential spread of infection.

Infection control training was provided by the home and was part of the mandatory training units. However, four of the five staff whose training records we observed were out of date with their infection control training. Cleaning schedules were seen and we observed tasks were completed appropriately. Domestic staff were observed cleaning communal areas. However, the cleaning did not appear to be effective.

Infection control meetings were held on an ad-hoc basis. We observed minutes from these meetings which had been held in February 2016 and April 2016, but there were no recorded auditing outcomes or areas identified for improvement.

Environmental risks affecting people had not been identified appropriately. There were stair gates at the bottom of the stair wells, preventing people from using the stairs to access the first floor. We spoke with the registered manager about the risk assessment for these stair gates, they did not identify that this may restrict people's freedom within the home and there had been no risk assessments completed for them. The registered manager completed the risk assessment during our inspection, but mentioned details such as 'trapping people's fingers' in the gates, rather than the deprivation of liberty concerns regarding restricting people's freedom of movement. Other risk assessments, relating to people's individual health needs had been completed appropriately by nursing staff. For example manual handling risk assessments had been completed fully, were person centred and reviewed regularly.

A failure by the provider to assess the risks to the health and safety of service users receiving care and treatment and doing all that is reasonably practicable to mitigate any such risks, and the failure to assess the risk of, preventing, detecting and controlling the spread of infection is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave good examples of how to identify signs of potential abuse and how to protect people from abuse and avoidable harm. They knew how to report any concerns and felt they would be dealt with by the

registered manager. Staff knew about the whistleblowing policy and felt they would refer to this if they needed to. There were examples of concerns having been thoroughly investigated by the registered manager and the local safeguarding authority having been informed. However, we saw that the Commission had not received notifications for the same safeguarding concerns.

There were sufficient numbers of staff available to keep people safe and meet their needs. Staff rotas showed there were a consistent number of nursing and care staff available each day to meet the needs of people. However, there was no tool in place to identify what people's needs were and how staffing levels were adapted to meet people's changing needs. The registered manager told us the provider was looking at a suitable tool to be implemented across the service to clearly identify the dependency and staffing needs of the home. The home engaged the services of agency nurses on a regular basis. The registered manager told us they used agency nurses and care staff who had worked at the home regularly and knew people and staff well. This was confirmed by permanent members of staff.

Medicines were safely managed within the home. They were ordered, stored, administered and recorded appropriately. MAR charts were completed well, with no gaps. The process for managing controlled medicines was safe. Two signatures were provided on documentation when a controlled drug was to be administered and the stock checked during inspection was correct. Senior nursing staff were able to provide a comprehensive overview of the ordering and disposal of medicines, with unused or discontinued stock being returned to the pharmacy. There was clear documentation in place for the administering of 'as required' (PRN) medicines and a process for staff to follow in relation to 'homely remedies' which was also documented appropriately. Pain charts were available for people, and those observed were completed daily at all medicines rounds. Medicines were administered by appropriately trained staff who had all completed their annual update in relation to medicines competency.

Some people were given medicines covertly. A senior nurse was able to explain the process for covert medicines which involved the pharmacy, family members and GP. There was clear documentation which included GP statement and pharmacy advice as to what foods would be best suited to the covert process. We saw documentation confirming monthly medicines reviews for people who were provided with medicines covertly.

The provider followed safe recruitment practices. We looked at five staff members' recruitment files and saw appropriate steps had been taken to ensure staff were suitable to work with people. Disclosure and Barring Service checks (DBS), professional references, and photographic identification checks had been made for all five staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People felt supported by staff who knew them well and were suitably trained to carry out their role's effectively according to people's needs. One person said, "They know me, yes they know me pretty well. They know what they're doing." People were offered a choice of foods and supported to maintain a healthy diet. One person said, "The food is quite good, I haven't left a meal yet!"

The home was in a poor state of decoration and did not promote a dementia friendly environment which did not meet the needs of people living at the home. Carpeting throughout the home was worn, stained and in some areas taped down to prevent a risk of falls. In people's bedrooms, handles were missing from wardrobes and chests of drawers and paintwork was marked and chipped. The corridors were painted beige as were people's rooms, there was little to orientate a person with memory problems as to their surroundings. Some rooms had the name of the person on the door but the font was very small and difficult to read. Pictures of people were not always on the doors of their rooms but on the walls to the side which again might be confusing for people in trying to locate their room and orientate themselves to their surroundings. Pictures on the walls appeared to be old and were dull in colour with no dementia friendly art work, colour or focus. There was a lack of signage within the home to assist people in locating where they wanted to go. The provider told us they had plans to invest in redecoration and in new flooring.

The failure by the provider to ensure that premises were clean, suitable for the purpose for which they are being used and properly maintained was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During induction, there was evidence that staff received required training on important elements which enabled them to care for people effectively. The skills covered included, moving and handling, safeguarding, food hygiene, health and safety and infection control. Required training updates were held annually for staff and were taught both online and in face to face teaching sessions. These sessions were held to refresh staff's knowledge which would enable them to maintain their skills to continue to meet the needs of people living at the home. However, upon review of the staff files, all five had at least one out of date required training element and were overdue for updates by at least a year, which could prevent staff from being able to carry out their roles effectively.

Induction for new staff was based on the 15 standards of care in the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received regular supervision sessions which staff felt were meaningful. Staff and records confirmed this. Supervision offered staff the opportunity to discuss any training and development needs which enabled them to carry out their role effectively, or to receive feedback on their performance. Documents confirmed staff had also received an annual appraisal.

Staff gave some examples of the need to provide care and support with the person's consent. We saw examples of staff explaining what they were about to do and making sure the person understood. However, we also observed interactions between people and staff where consent had not been sought.

The Mental Capacity Act 2005 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 the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Documents confirmed applications had been made under DoLS but the applications once made, were not followed up, reviewed or renewed when granted. For example; one application that was made on the 22 December 2014 had not been followed through, the DoLS authorisation could not be located. Another example was an application made on 18 December 2014, again there was no evidence to confirm that the application had been granted, chased or any follow up efforts made by the management team. DoLS applications had been made fully after mental capacity assessments had been completed. However, the service could not be assured that people living in the home had the appropriate DoLS authorisations in place to account for the restriction to their liberty.

People were supported to maintain a balanced diet and fluid intake. We observed people being offered drinks at regular intervals throughout the day with two food choices being offered at mealtimes which included a vegetarian option. If people did not want what was on the menu the kitchen would prepare an alternative such as, salads, omelettes, soup, filled jacket potatoes, fresh fruit, yoghurt, mousse and ice cream. One person told us, "I have a choice of food, I had cereal for breakfast with coffee. I had a choice of tea or coffee, I always have coffee." Another person told us people get drinks whenever they wanted them. The kitchen catered for people who required a specialised diet, such as pureed food. A relative told us, "My [relative] participated in a cream tea event even though she is on a pureed diet. Staff stayed with her and broke the scones into small pieces and mixed them with jam and cream".

Documentation was seen during our inspection of when people had been supported to access external health care professionals. GP's, district nurses, opticians and chiropodists had visited the home or people have been accompanied by care workers to attend appointments at the hospital. One relative said, "My [relative] has the chiropodist in to see her at the home regularly."

Requires Improvement

Is the service caring?

Our findings

People and their relatives felt the care provided within the home was of a good standard. One person said, "the staff are friendly." Another person said, "[Registered manager] treats me like a friend, I love living here." A relative said, "Staff are prepared to listen and were patient with [relative], they never refused her. Very Good."

People felt able to express their wishes regarding their care and that they would be listened to. Staff took people's individual preferences into account when supporting them or providing care. People told us they were able to discuss any concerns with nursing and care staff, or with the registered manager and that matters would be addressed; leading to a satisfactory outcome. One relative told us, "I have seen the care plan and have had input to it, and I query its' content." The person confirmed that their issue was dealt with appropriately.

Some staff appeared to know people well and addressed people warmly. We observed, caring interactions between staff and people living at the home and we further observed some care staff who did not engage with people. For example; standing to the side of the communal lounge or watching television when they did not have a task to complete, even though there were people sitting in the lounge and dining areas during this time. During one observation, two care workers supporting a person with mobilisation, were talking about the person they were supporting without including that person in the discussion.

There were some examples where staff showed compassion whilst respecting people's privacy and dignity. During one example, we observed a person who became unwell within the communal lounge, care workers immediately went to support the person surrounding them with a privacy screen and talking to them in a quiet, reassuring manner. However, there were other occasions where we observed interactions between people and staff where staff did not respect people's privacy and dignity. For example; whilst supporting one person to use the toilet, staff left the door open so that anyone passing would be able to see in to the bathroom. On another occasion we observed a member of staff saying loudly that they wanted to assist a person to the bathroom as they had been incontinent. This was loud enough for everyone in the lounge to overhear. Equipment was not always in place to support staff to respect people's privacy and dignity when providing their care. For example, shower curtains/screens were not in place in the communal bathrooms and therefore people when showering did not have the option to cover themselves/ to be covered in order to protect their privacy and dignity

Staff gave examples of covering people whilst providing personal care, and encouraging people to undertake tasks that they were physically able to, so as to support people with maintaining their independence.

The failure by the provider to treat people with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations
2014.

Compliments had been received by the service regarding the care provided. One comment received from a relative said, "the staff at Peel House care like each resident is their own family member." Another compliment received from a relative stated, "thank you for looking after [relative] so well and all your kindness".

Requires Improvement

Is the service responsive?

Our findings

People's care and treatment was based on pre admission assessments and care plans which were designed to meet their needs and take into account their preferences and wishes. Care plans identified people's needs and preferences in relation to personal care, eating and drinking, mobility, what activities they liked to engage in and more specific actions required to support them. There was detailed information regarding people's health, medication history and evidence of multi-disciplinary team (MDT) meetings having been held, with clear documentation and guidelines for staff to assist them in meeting people's needs.

People's bedrooms were not well individualised. There was little in the way of personalisation. Some rooms had photographs in frames and televisions, but many rooms did not. Some rooms looked uninhabited despite people being resident in them. Most rooms were painted beige with similar bed linen in each room. Rooms did not feel homely or welcoming.

People's activity preferences were included and available in their care plans; however these did not appear to be taken into account on a daily basis. The provider told us there were two activity co-ordinators but one was on long term leave and the second activity co-ordinator had been in post for a matter of weeks. The provider confirmed they were regenerating the activities available for people but there was no further information available in relation to this.

People were not always involved in stimulating activities, or activities of their choosing. We observed in the communal lounge area, people sat in chairs for long periods of time. One person told us in the afternoon, "I've been sitting here since 9am this morning." During inspection we observed colouring books that had been placed in front of people sitting in the communal area. However, people were not colouring and staff did not engage with people in relation to this activity, or ask whether people were interested in colouring. One person expressed an interest in playing dominoes, but said the activities co-ordinator had not played dominoes with them, although they had with another person. We also observed a member of staff throwing a soft ball back and forth with a person. The person looked disinterested and did not look as though they were enjoying the activity.

During each shift, staff were allocated particular people to care for and were responsible for all the personal care and support for that person during that shift. During our inspection we observed one person asking a passing care worker if they could help them get to the toilet. The care worker replied, "I will find the person who is looking after you, it might be a while." We observed this person waiting several minutes before their assigned care worker came to assist them. A responsive, flexible service should have been able to accommodate the need without delay.

People had been involved in the planning and review of their care which was recorded in individual care plans. People felt actively involved in making decisions about their care. Relatives told us they could speak with staff members at any time and their concerns would be listened to.

People were able to access hairdressing services within the home and local churches provided some

support for those wishing to engage in religious activity.

There was a complaints procedure in place. We observed three concerns had been raised within the previous six months. One complaint was in relation to the temperature in the conservatory, another was in relation to the length of time it took for a care worker to assist their relative to the toilet. Both had been addressed by the provider in a timely manner, investigated and where appropriate an apology had been sent to the complainant.

Requires Improvement

Is the service well-led?

Our findings

People spoke well of the registered manager. One person told us, "[name] is very caring. She comes and chats to me in my room." Staff told us the registered manager was approachable and operated an open door policy. They felt they could go to them with any problems, having confidence that the matter would be effectively resolved within a timely manner.

There was a lack of complete and contemporaneous record keeping in relation to DoLS. Although applications had been submitted for people, there was no process in place to monitor whether DoLS authorisations had been granted, reviewed or reapplied for when required.

There was a lack of quality auditing systems and management processes in place to assess, monitor and improve the quality and safety of the service provided. Whilst there was some evidence of audits having taken place, they appeared to be ad-hoc, with no evidence of how practice had been changed as a result and no plan for continued evaluation. For example; some call bell audits had been completed, but once areas for improvement were identified, there was no clear action plan in place for matters to be resolved, or for future audit to embed improvement. The audits had not identified the concerns we had found during the inspection to sufficiently address shortfalls in the physical environment, in terms of dementia friendliness and safe upkeep/infection control, nor the lack of clarity over DoLS administration needs or training refresher dates slipping.

Feedback had not been sought by people living at the home or their relatives in relation to how the service was managed. As a result, people had no formal way of telling the registered manager and provider what was working well and what could be improved. Residents, relatives and staff meetings had been held sporadically, but one relative said "I did go to one meeting but didn't bother going to the next one as nothing was done about the issues raised in the first."

The failure by the registered person to seek and act on feedback from people about the service provided to continually evaluate and improve services, the failure to establish systems or processes to assess, monitor and improve the quality and safety of the service and the failure by the provider to maintain accurate, complete and contemporaneous records in relation to DoLS was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were three safeguarding concerns within the safeguarding folder. Whilst these had been investigated and there was clear documentation to evidence this, with the local safeguarding authority having been informed, the Commission had not been notified about any of these safeguarding concerns. The registered manager told us that they were unaware of the necessity to notify the commission of these incidents as they had been reported already to the local safeguarding authority and they believed this to be sufficient.

A failure to notify the Commission of safeguarding concerns is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager felt well supported by the provider with regard to the day to day management of the home. The manager was supported in her role by regular supervision sessions and appraisal.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents A failure to notify the Commission of safeguarding concerns is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The failure by the provider to treat people with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A failure by the provider to assess the risks to the health and safety of service users receiving care and treatment and doing all that is reasonably practicable to mitigate any such risks, and the failure to assess the risk of, preventing, detecting and controlling the spread of infection is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014

personal care	Premises and equipment The failure by the provider to ensure that premises were clean, suitable for the purpose for which they are being used and properly maintained was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure by the registered person to seek and act on feedback from people about the service provided to continually evaluate and improve services, the failure to establish systems or processes to assess, monitor and improve the quality and safety of the service and the failure by the provider to maintain accurate, complete and contemporaneous records in relation to DoLS was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.