**Inspection Report**

**We are the regulator:** *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

**Dorset Learning Disability Service - 56 Maiden Castle Road**

56 Maiden Castle Road, Dorchester, DT1 2ES

Tel: 01305265097

Date of Inspection: 13 December 2013

Date of Publication: January 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to care and treatment</td>
<td>✓</td>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
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<tr>
<td>Management of medicines</td>
<td>✓</td>
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<tr>
<td>Staffing</td>
<td>✓</td>
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<tr>
<td>Complaints</td>
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</tbody>
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## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Leonard Cheshire Disability</th>
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<tbody>
<tr>
<td>Registered Manager</td>
<td>Ms. Jane Street</td>
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</tbody>
</table>

### Overview of the service

56 Maiden Castle Road is a detached property in a residential area of Dorchester. It provides personal care and accommodation for up to four people with a learning disability.

The home will be temporarily vacant for a period in 2013, due to the property undergoing extensive renovations. The dates for the building works were not confirmed at the time of our inspection, due to the provider being in the process of making arrangements for people to move into suitable alternative accommodation.

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Care home service without nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulated activity</td>
<td>Accommodation for persons who require nursing or personal care</td>
</tr>
</tbody>
</table>
When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of this inspection:</td>
<td></td>
</tr>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
<tr>
<td><strong>Our judgements for each standard inspected:</strong></td>
<td></td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>6</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>9</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>11</td>
</tr>
<tr>
<td>Staffing</td>
<td>13</td>
</tr>
<tr>
<td>Complaints</td>
<td>15</td>
</tr>
<tr>
<td><strong>About CQC Inspections</strong></td>
<td>16</td>
</tr>
<tr>
<td><strong>How we define our judgements</strong></td>
<td>17</td>
</tr>
<tr>
<td><strong>Glossary of terms we use in this report</strong></td>
<td>19</td>
</tr>
<tr>
<td><strong>Contact us</strong></td>
<td>21</td>
</tr>
</tbody>
</table>
Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 13 December 2013, observed how people were being cared for and talked with carers and / or family members. We talked with staff.

What people told us and what we found

We were unable to speak with people who lived in the home due to their complex needs. We spoke with three relatives of two people who lived in the home, via the telephone and in person. People's relatives told us that they felt positive about the quality of care people received and with their relationships with the staff.

We observed residents moving freely around the home and interacting with the staff in a relaxed way.

People's relatives told us that the people who lived in the home were asked for their consent when making choices and decisions about their daily lives; and that people's choices and decisions were respected by the staff. A person's relative told us, "She can communicate her consent. She can let them know. We are all working together. I am included in decisions."

The home had procedures in place to ensure that people received their medicines as prescribed. Medicines were handled in a secure way. A person's relative told us, "There haven't been any errors with her medication."

We found that there were sufficient numbers of staff, with the right competencies. A support worker told us, "Leonard Cheshire are very good at promoting staff getting qualifications. That was one of the reasons I came here."

The home was taking account of people's comments or complaints. People's relatives, told us that they could be sure that their comments were listened to, and responded to appropriately.

You can see our judgements on the front page of this report.
More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Consent to care and treatment</th>
<th>Met this standard</th>
</tr>
</thead>
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<tr>
<td>Before people are given any examination, care, treatment or support, they should be asked if they agree to it</td>
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</table>

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Overall, we found that the home gained people's consent, prior to providing them with care and support. We found that people or their representatives, understood and knew how to change any decisions about their care and support, and that people's human rights were respected.

During our visit we spoke with the relatives of two people who lived in the home. A person’s relative told us, "I am currently applying for a power of attorney with health and welfare decisions. But, they have been very good in consulting us about things before they do anything; and asking about her likes and disliked."

We saw that people's agreement was sought prior to staff supporting them. For example, we saw a person being asked if they would like to sit in the lounge or the dining room. We saw a support worker asking a person if they were ready to go for a walk. We saw the support worker accompany the person on a walk. A relative told us, "I've been well impressed with the way they have tried to communicate with her. If they aren't sure, they always check things out with us."

We saw that people had care plans in place in regards to decision making. One person's care plan recorded, "It is important for staff to remember that when communicating with me they should use key words and simple instructions."

The team leader told us, "We ask people about their preferences on a day to day basis." A senior support worker told us, "People here are capable of letting us know if they don't consent, even if it is only that they walk away. We are always learning about the people here, it is on-going."

A senior support worker told us that there was no person in residence at the home who was the subject of a Deprivation of Liberty Safeguards (DoLS) assessment. DoLS ensure that there are systems in place so that if a person lacks the capacity to consent to their
care or treatment, their freedom is not restricted more than necessary, and any restriction is in their best interests.

The team leader told us, "If we have any doubt about DoLS we always seek advice from the county council. We are very aware. For example, we use stair gates upstairs, as we have a resident who will get up in the night and walk around. There is a risk with the stairs. We have sensors in the room that alert staff when she gets up. But, we contacted the county council about the use of the stair gate, and whether we needed a best interest assessment. They told us we didn't; as sleeping in staff would get up and let her out as soon as they heard the sensor alarm. The gate is only there to ensure that she doesn't go to the stairs before staff get to her room." We saw that the person had an up to date risk assessment in place in regards to the use of the stair gate.

We looked at three people's care records. We noted that people's paper based care records were well organised and accessible. The team leader told us that work was in progress on introducing the provider's new procedures and care planning documentation. The team leader told us, "We are introducing new person centred plans, commencing in January. All the information in these files will be transferred into the new PCP documentation."

We saw the new care planning documentation. This contained comprehensive materials for the planning of people's care, and a consent form that comprehensively covered data protection, discussions about service provision, medication, support preferences, audio/visual materials, and consent to personal care. A senior support worker told us, "We have started asking people and their families to complete the consent forms from the new PCP."

We saw that the care records we viewed contained the provider's procedure for 'making decisions on behalf of the service user in line with the Mental Capacity Act 2005.' This meant that people were not at risk of being excluded from making decisions for which they were mentally capable. The guidance informed staff on actions they should take in testing people's capacity, and gave instructions on who they should consult in the event that a person lacked capacity.

We saw that a person's records had a 'record of best interest consultations and decisions where a person is believed to lack capacity and LCD is the decision maker'. As the person had been involved in a best interest decision in regards to receiving a flu jab. The person did not have any family who the home could consult. We saw that the team leader had contacted a local advocacy service and that health professionals had been involved in the decision making process. The least restrictive alternative had been identified during the consultation process. This led to the person receiving their flu jab, whilst minimising the anxiety the situation could have potentially caused them.

We spoke with two support workers and a senior support worker. They all confirmed that if they were concerned about a person's capacity, they would inform their line manager. The staff we spoke with told us that they had received training in the Mental Capacity Act 2005 (MCA). We viewed staff training records, and saw that most staff had received MCA training.

Following our inspection we spoke with the service manager via the telephone. They told us, "I have recently met with team leaders and the TDO (training and development officer). We are planning to do some further internal training with staff on our mental capacity act
procedures and documentation."
Care and welfare of people who use services

Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Overall, we found that the people who use this service were involved in their assessment and care planning, and were treated with dignity and respect. We also found that the home was acting on advice and recommendations to ensure people were protected from inappropriate care or treatment.

During our inspection we looked at three people's care records. A team leader also explained the home's assessment procedures. We saw that people's care records contained pre-assessments. These were the initial assessments the home completed. A team leader told us, "At the pre-assessment we visit them and they visit the home. We get information from the people who were supporting them." We saw that the home had produced a transitional plan to facilitate a person's move into the home in 2013. The plan included staff visiting the person at their former home to build a relationship with them, as well as the person having structured visits, and stays at the home, prior to their moving in permanently. The person's relative told us, "We were kept informed the whole time, and everything was set up for her."

We viewed three people's paper based care records. We noted that the care records contained support plans that followed the home's procedures for assessment and care planning. People's records identified people's eating and drinking needs, daily routines and personal hygiene, and communication needs. For example, we saw that a person's daily routines care plans was very detailed and structured by the hour. The care plan recorded, "8.30 – 9.30. Comes down stairs carrying their dirty washing; puts that in the wash bin; then chooses what cereal she wants for breakfast. Gets her bowl out; does her own cereal; then her drink; then fruit; spoon; tray; apron. Then puts away the cereal and milk." A senior support worker told us, "We have put very structured routines in place with her, and she has responded really well to it. Her behaviour has really improved."

We saw that the home's individual support plan (ISP) care planning system was used to ensure that assessments and care plans identified people's specific needs and risks to people's wellbeing. People's ISP's contained behavioural support plans. We spoke to the NHS community learning disability nurse via the telephone. They told us, "A service user had challenging behaviour; and through them working closely with us and other
professionals, the frequency of episodes has really reduced."

We saw that people's records contained risk assessments. These included plans for supporting people in the home and when 'out and about' in the community. This meant that the risk of people receiving inappropriate care and treatment was reduced because the home was assessing people's needs, and planning appropriate care to meet people's identified needs. We noted that people's care had been reviewed regularly. During our visit we spoke with three relatives of people who lived at the home. The relatives we spoke with told us that they were involved in how relatives their care was provided. A relative told us, "We know she has a care plan. We've seen it and we are happy with it."

We heard staff speaking to people in a respectful and polite manner. A senior support worker told us, "If people here can communicate verbally, we involve them in their care planning. We involve families and friends. We also involve the learning disability nurse and psychiatrist." The NHS community learning disability nurse told us, "They do promote people's dignity and respect."

Relatives of people who lived in the home told us that their family members were supported to access healthcare professionals if needed. A relative told us, "They always let us know if she's not well or if she's seen the doctor." We saw staff telephoning a G.P during our visit, in regards to a person who had a virus. We saw the team leader discussing with staff what actions should be implemented to ensure that the person received appropriate care; and how to best isolate the person from other residents to minimise the risk of other residents being exposed to the virus. We saw staff behaving in a kind and compassionate way to the person who was suffering from the effects of the virus.

We saw that people's records contained records of people's appointments with or visits to other professionals. These recorded who the professional was, the reasons for the appointment, and any outcomes and advice given. The NHS community learning disability nurse told us, "They are very good, very observant. They always follow up on my advice. They are very pro-active. If they think things aren't right with people they contact us for advice."

The home had procedures for recording accidents and incidents. We viewed the provider's 'reporting of and learning from serious incidents guidance and procedure'. This gave staff guidance on the provider's reporting procedure. The guidance also included information on how the provider would monitor incidents to ensure that lessons were learnt to reduce the risk of similar incidents occurring.

We asked a senior support worker about the home's procedures in the event of emergencies or situations that could lead to disruptions in services. The senior support worker showed us the home's emergency plan. This included the telephone numbers for utilities providers and the location of the home's mains supplies of electricity, gas, and water.

We saw that people had personal emergency evacuation plans, (PEEP's), in place. The team leader told us that in adverse weather conditions, "We have an employee with a 4X4. We could get people in to work." This meant that people were protected from emergencies or situations that could lead to disruptions in services.
Management of medicines

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Overall, the home was protecting people against the risks associated with the unsafe use and management of medicines, by means of the appropriate administration and management of medicines.

We saw that medicines were stored securely in locked medication safes in people's bedrooms. This meant that the home had appropriate arrangements for the safe keeping and handling of medications. A senior support worker told us that no medicines were in use that required refrigeration.

During our visit we saw a person going to visit their family for the weekend. We saw staff signing out and preparing the person's medications for the visit. Staff also completed a record of medications to be taken out of the service form. We asked a relative about the home's medications handling. They told us, "There haven't been any errors with her medication. She brings her medications with her when she visits. I sign to acknowledge that I've received them and I sign them back in when she returns."

We did not see any medicines being administered to people at the time of our visit. However, we viewed people's Medical Administration Records (MAR). Staff we spoke with told us that they provided people with drinks of water to enable their swallowing of tablets. Staff told us that they supervised people until they were sure the medicines had been taken. A senior support worker told us, "We have a medications double check system. A member of staff checks blister packs and amounts daily. Then another member of staff checks them again."

A support worker told us that the home did not have anybody in residence that self-administered their medication at the time of our visit. We saw that people had signed consent agreements for staff to administer their medications.

We noted that entries on the MAR had been signed. We also saw that staff signed a form to say that they were familiar with the home's medications policy and procedures. Staff also provided examples of the style of initialling they would use on people's MAR records to aid the team leader in identifying which staff member had completed the MAR record.
senior support worker told us that medications were audited monthly.

We saw that people's prescriptions were up to date, and that new quantities of medication were recorded on the MAR. A support worker told us that staff recorded in full the reasons why medicines had not been administered, by completing a code on the MAR, and recording the reasons why medicines had not been given on the reverse of the MAR. This meant that people's medications were given to people in line with their prescriptions.

A senior support worker told us, "Returns are sent back to the pharmacy. We record returns in the returns book and record it on the MAR." We asked the senior support worker about reporting medication errors. They said, "We haven't had any medication errors since I've been here. The double checking means that we would locate an error early. If we did have an error we would inform the team leader; and call the G.P or NHS direct. We would also report it to safeguarding."

We were unable to view the home's controlled drugs storage or register at the time of our inspection. A senior support worker told us, "We don't have any controlled drugs." The team leader told us, "We have a controlled drugs safe in the office. This would be used for any of the homes in the area, as the individual home's don't have controlled drugs safes. A member of the maintenance staff would install the controlled drugs safe in the home, if we had them prescribed." This meant that the home had arrangements in place for the safe administration and disposal of medicines.

We saw the home's medications policy. This was comprehensive and available on the provider's intranet. A senior support worker told us, "We all have access to the internet and the intranet. If we have any queries we can look up the policy or procedure." This meant that staff had access to guidance on the PRN protocol, safe supply, receipt, storage, administration, security, disposal, and returns to the pharmacy; medication errors; and the safe handling of controlled drugs.

A support worker told us, "We have had medications training. We can't administer medication until we have completed it." A senior support worker said, "We do regular competency checks and observations of staff medications practice."

We saw that the home had a pharmacist audit on the 16 October 2013. The pharmacist audit recorded, "Really good standard in place. MAR completed properly. Storage and stock levels appropriate. Cream chart in place."

A senior support worker showed us a quick reference guide that the Leonard Cheshire Dorset Disability Service had produced. This provided staff with accessible guidance on the safe administration of medication. The senior support worker told us, "If we need information or need to consult the medications policies we can look it up on the intranet or internet." This meant that the home was taking account of published guidance on the safe use of medicines.
Staffing

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

Overall, we found that people's care needs were met by sufficient numbers of appropriately skilled and experienced staff.

During our visit we spoke with a senior support worker and two support workers. A support worker told us, "I've been here since March. But, I've worked for Leonard Cheshire for eleven years. I've got NVQ level 2 and 3 – We've got a good team, we all work well together." Another support worker told us, "I've been here since March. I have NVQ 2 and I am starting level 3 in March. I like working here. I love working with the ladies here."

We viewed the home's staffing rota and shift plan. We saw that staffing levels were consistent with the rota. A support worker told us, "We have quite a high staff ratio. We have three staff during the day."

We asked relatives about the home's staffing levels. A person's relative said, "There are always enough staff. They are very good with my daughter and very understanding of her." Another person's relative said, "There are enough staff here; but, there were a lot of staff changes earlier this year. It was unsettling for people, as there was a lot of new staff for them to get used to; but, it all seems to have settled down quite well now."

A senior support worker told us that the home covered staff absence, holiday and training by staff volunteering to take on extra shifts. They said, "We ask our own staff to volunteer for extra shifts. If we couldn't cover with our own staff, Leonard Cheshire have bank staff we can draw on. But, we can usually cover absence with our own staff in this house. Our staff will help out." This meant that there was enough staff who knew the needs of people who lived in the home, to ensure that people experienced a consistency of care.

The registered manager told us that they audited staff: annual leave; sickness absence; and staff training hours on a monthly basis. This meant that the service had management structures and clear human resource procedures that were followed in practice, monitored and reviewed, that enabled the effective maintenance of staffing levels.

We saw that comprehensive policies and guidance, as well as e-learning, was available to
staff on the provider's intranet. A support worker told us, "There are enough staff here to cover most emergencies. I've come in today, just to help out, as we have a person in the house who is ill."
Complaints

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

Overall, we found that people’s comments and complaints were listened to and acted on effectively. The home had systems in place to support people who used services or others acting on their behalf to make comments and complaints.

We spoke with the relatives of two people who lived at the home. A person’s relative told us, "I called a review meeting today with the nurse and the home’s manager, as my daughter has a long-term health issue. We are all working together. I am included. I would know how to make a complaint; but, I like to nip things in the bud and deal with them. If I have any concerns I speak to the manager. They have always dealt with any issues I have raised appropriately."

A team leader told us the home’s complaints system was brought to the attention of people who live at the home, and their relatives, via the home’s service user guide. A person’s relative told us, "You do worry about your children; and you hear stories on the news. But, I think they’re marvellous. I’ve never had a complaint. I do have information on complaints. They gave me a folder with lots of information."

We saw that people’s care records contained a, ‘Have your say’, booklet. This detailed the home’s complaints procedure in pictorial and easy read formats. A senior support worker told us, "We haven’t had any complaints since I’ve been here. If we feel there are any issues we try to reach an understanding with the families; before it gets to being a complaint."

We viewed home’s published complaints policy and procedures. The policy set down timescales for the acknowledgement of, and investigation into, formal complaints. We also viewed the provider’s guidance for staff, ‘dealing with customer feedback.’ This gave staff guidance on how to manage people’s concerns. The team leader told us that complaints would be monitored by the service manager as an aspect of the provider’s quality assurance monitoring. This meant that the home had procedures in place to ensure that complaints relating to the care provided to people were appropriately investigated.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✔ Met this standard
   This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed
   This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken
   If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services - Outcome 1</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment - Outcome 2</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services - Outcome 4</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs - Outcome 5</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers - Outcome 6</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse - Outcome 7</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control - Outcome 8</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines - Outcome 9</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises - Outcome 10</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment - Outcome 11</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers - Outcome 12</td>
<td>21</td>
</tr>
<tr>
<td>Staffing - Outcome 13</td>
<td>22</td>
</tr>
<tr>
<td>Supporting Staff - Outcome 14</td>
<td>23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision - Outcome 16</td>
<td>10</td>
</tr>
<tr>
<td>Complaints - Outcome 17</td>
<td>19</td>
</tr>
<tr>
<td>Records - Outcome 21</td>
<td>20</td>
</tr>
</tbody>
</table>

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.
<table>
<thead>
<tr>
<th>Contact us</th>
</tr>
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<tbody>
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<td><strong>Phone:</strong></td>
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<td><strong>Email:</strong></td>
</tr>
</tbody>
</table>
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