Review of compliance

Royal Cornwall Hospitals NHS Trust Royal Cornwall Hospital	
Region:	South West
Location address:	Treliske Priory Road Truro Cornwall TR1 3LJ
Type of service:	Acute services with overnight beds Long term conditions services
Date of Publication:	January 2012
Overview of the service:	Royal Cornwall Hospital is situated in Truro, Cornwall. It is part of the Royal Cornwall Hospitals Trust (RCHT) which also consists of West Cornwall Hospital (Penzance), St Michaels Hospital (Hayle), Penrice Birthing Unit, at St Austell Hospital (provision of approximately 750 beds between them) and RCHT Headquarters who manage

	community services at other sites throughout Cornwall. This is an acute hospital with services such as a 24 hour accident and emergency department, maternity unit, outp

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Royal Cornwall Hospital was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 06 - Cooperating with other providers
Outcome 13 - Staffing
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

People told us that the staff are always very busy but despite that they cannot praise them enough. They added that 'everyone is lovely', 'staff are wonderful', 'wonderful staff and Doctors' and that they are 'looked after well'. One person, on the Surgical Receiving Unit, said that they had been waiting for a wash for over an hour. One person said that they had once been nil by mouth for four days because the list kept getting cancelled and that an intravenous drip was not quite the same as eating.
People who use the service and staff consistently told us that there were not enough staff.

People said that staff communicated with them well and they felt informed about their conditions and what would be happening to them.

People told us that (especially on the Medical Assessment Unit and Wheal Agar Ward) that it is noisy at night, with staff making a lot of noise with no effort to be quiet. They added that some of the equipment is also noisy.

We were told by patients, on Wheal Agar Ward, that there is no access to a television and that they sit by their bed all day with not a lot to do.

People using the service said although the staff are busy they can ask them questions or speak to them if they have any concerns. Relatives we spoke to said they had felt included

for example when their relative had returned from the operating theatre.

What we found about the standards we reviewed and how well Royal Cornwall Hospital was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People experience effective, safe and appropriate care and support.
Care plans are not consistently completed to ensure that staff know about the care and support required to meet people's needs.

Outcome 06: People should get safe and coordinated care when they move between different services

People using the Royal Cornwall Hospital receive safe and coordinated care and support.

Where other organisations and health care professionals are involved, effective systems have been/are being developed to ensure interagency support is appropriate and effective.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People's needs are being met by sufficient numbers of staff. Delays in care and support being given sometimes occur because staff are very busy.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The Royal Cornwall Hospital has systems in place which ensure staff are supported in their role.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that the staff are always very busy but despite this they cannot praise them enough. They added that 'everyone is lovely', 'staff are wonderful', 'wonderful staff and Doctors' and that they are 'looked after well'.

People said that staff communicated with them well and they felt informed about their conditions and what would be happening to them.

One person, on the Surgical Receiving Unit, said that they had been waiting for a wash for over an hour. One person said that they had once been nil by mouth for four days because the' list' kept getting cancelled and that an intravenous drip was not quite the same as eating.

People told us that (especially on the Medical Assessment Unit and Wheal Agar Ward) that it was noisy at night, with staff making a lot of noise with no effort to be quiet. They added that some of the equipment was also noisy.

Other evidence
On the Surgical Receiving Unit the staff use pre-printed care plans that include a number of risk assessments to complete, for example; falls risk, nutrition status, use of bed rails and infection concerns. One that we looked at did not have the discharge/transfer plan completed but did have good daily evaluation records regarding the persons progress. Another one had all the risk assessments completed. All of the care plans we looked at on this unit had had the nursing assessment part completed

and they were all signed and dated.
A staff member said that they try to complete the documentation with the person as much as possible but that it was not always reasonable to do so

On the Medical Assessment Unit we saw that a box filled with medication (dosette box) was left unattended for at least 20 minutes in an area that was accessible to patients.

On the same unit we saw that some dirty laundry was thrown onto the floor before being put into a laundry skip and at least one screening curtain was dirty and coming off its rail meaning it was dragging on the floor. The Trust told us after our visit that the curtain had been identified and repaired.

A member of staff said that they looked in the medical records sometimes when trying to find out how to care for a person. A trained nurse, when asked, had difficulty locating completed risk assessments as they were not in the care plan.

The Trust policy is that the 'risk assessment pack' for a person's care plan should be completed within six hours of admission (six hours is stated on the front of the pack). We saw that one persons care plan we looked at did not have the nutritional risk assessment, pressure ulcer risk assessment and manual handling risk assessments completed, although they had been on the unit for more than six hours. In the daily evaluation for this person one day it said that the person was being nursed on their side due to developing sacral soreness/redness, but no open wound yet. The next day there was no record of pressure area monitoring ongoing.

Another care plan we looked at had a completed falls screening tool, infection prevention and control risk assessment, bed rails assessment and a manual handling risk assessment. The nutrition risk assessment tool or the pressure ulcer risk calculator were not completed. The person had to have intravenous fluids; the associated fluid balance chart was not dated, the urine output chart was not dated and the initial observation chart (Modified Early Warning System (MEWs)) had not been completed.

Another care plan reviewed had no specific plan for pressure relief. A trained nurse went through the notes and could not find one or a completed pressure sore risk assessment. She said that she had checked the person's skin that morning and was about to do it again. She did not know why the documents had not been completed.

On Wheal Agar Ward, that included some people who had a form of dementia, we saw that there were 'This is Me' documentation in use (a document developed by the Royal College of Nursing and the Alzheimer's Society that has important information about a person who may not be able to tell you themselves). We also saw 'life story' pocket books, that are designed to support person centred care, in use. We noted that there were no communal areas for people to socialise in or to eat meals in so people sat by their beds all day with no distractions and no access to a communal television.

One care plan we looked at for a frail individual included weight measurements, and a manual handling plan. The generic personal care and hygiene plan did not include individualised details for that particular person. The care plan for friction to a bone said they apply 'velband' and check regularly, it did not say how often to apply the 'velband' or how often to check the area.

Another person had no care plan for personal or skin care when the daily evaluation sheet identified dry areas on both legs. The evaluation sheet said help was needed to transfer the person but there was no mobility care plan, the evaluation sheet also said the person was having high energy diet and fluids but there was no nutritional care plan. The Director of Nursing told us that the notes on the nurse's station showed that a dietician had visited the person in question and had prescribed a number of measures which were all translated into the drug chart.

Following our feedback to the Director of Nursing she visited the people whose care plans we had noted as being incomplete. She told us that; 'The notes were kept in three different areas: 1. at the bottom of the bed (least confidential in nature) 2. In a folder by the door into the bay (drug chart & more confidential information) 3. Risk assessments and further medical & nursing notes in a folder on the nurse's station. She wondered if we had not seen all of the relevant documentation for the records we reviewed as when she reviewed the person's folder at the nurse's station all the risk assessments had been completed on 20 November 2011.
The ward sister then reviewed all of the notes for the patients in the ward and found that all but one patient had fully completed initial risk assessment documentation.

On Tolgus Ward (which caters for a number of different specialities) we saw that a number of staff had had some training in care for people with dementia and two staff members were 'dignity champions'. We also saw that there were memory boxes for use with people who have a form of dementia. People on this ward who needed help with their meals had them served on a red tray and were served last so that staff then had more time to spend with them.
During our observations on Tolgus Ward we saw that a person rang the bell and it was three minutes before it was answered. The nurse who answered it apologised for the time it took to be answered.

Two of the care plans we looked at on this ward had pre operative assessments carried out and risk assessments completed. The pre operative anaesthetic review, in one, was not completed but we were told that the anaesthetist would be completing it. The other one had no nursing assessment completed but did have the pre operative sheets completed. We were told that this person was a new admission so there had not been time to complete the records yet.

Two members of staff told us that the documentation was new, had been in use for about five months. One said that it was confusing and repetitive. Another said that the staff have been involved in devising the 'paperwork'.

On Polgooth Ward we were told about significant improvements that had been made over the last few months since an experienced manager had been appointed. We were shown a newsletter, which was produced by her for the staff, informing them of any updates and changes required to practice, but in an informal way that the staff liked. Staff said that they felt that they worked as a team and as a result motivation was good and complaints had significantly reduced.

One of the care plans we looked at on this ward had a number of the required risk assessments completed, apart from infection control. The nursing assessment that is partly derived from the risk assessments was minimal, with one word answers and it was not dated. It included information about the person's discharge plan and who had

been contacted as part of that process. There was no care plan in place for mental health issues or continence, both of which were an issue for this person.

We saw that in the operating theatres staff were continuing to use the World health Organisation (WHO) surgical safety checklist. We were told that new staff were shown how to use the checklist and saw it in use as part of their induction helping to embed its use in practice. Staff told us that they are required to submit five completed WHO surgical safety checklists per theatre per week as part of the ongoing audit of its use. The medical director said that the Theatre Safety Group continues to meet monthly to monitor ongoing theatre procedures.

The maternity unit offers a variety of services to people including day assessment and specialist bereavement care. We saw staff interacting well with people using the service and found the staff to be enthusiastic about their work.

Written evaluation records, of a person's daily progress and wellbeing, in the eleven care plans we looked at on the wards were generally of good quality and informative.

The Trust previously acknowledged that there had been areas of non compliance in completion of documentation and have put training/workshops in place to address this.

The Trust also told us that they had set up a 'pressure ulcer prevention work stream' in response to three pressure ulcers being reported within the Trust in September 2011. Part of the work stream was to provide staff with a pressure points educational leaflet. Staff we spoke to were not familiar with the leaflet and the only place we saw it displayed was on the delivery suite in the maternity unit.

Most of the wards/ departments we visited told us that they had their own internal quality assurance system as well as feeding into the Royal Cornwall Hospitals Trust audit systems.
We were told that staff make entries, into a computerised system, if they feel there has been/ or is a reportable incident such as a pressure sore or dangerous staffing levels possibly putting people at risk. These incidences are analysed by the Trust and any themes are reported and acted upon in the most appropriate manner and may include investigation by Royal Cornwall Hospital quality assurance team or their health and safety team.

Our judgement
People experience effective, safe and appropriate care and support.
Care plans are not consistently completed to ensure that staff know about the care and support required to meet people's needs.

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
People told us that they felt informed about their care and where they may move to within the hospital or to another service such as a community hospital.

Other evidence
We were told, on the Medical Assessment Unit, that the 'complex discharge team' (that includes a social worker) called each day to discuss people's discharge plans, packages of care that may need to be set up or existing packages of care they have at home that may need to be reassessed or restarted.

We were told that new documentation was being piloted for when people were admitted from and discharged back to care homes, to promote smooth transfers in each case.

Four care plans seen on Tolgus, Wheal Agar and Polgooth Wards had evidence of discharge planning in them and included information about having contacted a District Nurse, continence management and follow up by a physiotherapist.

On the Surgical Receiving Unit we were told that when people had been told they could go home their tablets were ordered and were expected to take no longer than two hours to arrive. If people needed to become an inpatient, we were told that staff 'handover' to the new ward/department was by telephone or face to face if possible. They added that if somebody went back to the care home from which they were admitted and there was no change in their care they do a handover to the staff at the home by telephone. If there were changes in a person's condition then a transfer form

was completed so that the care home staff had documented up to date information.

Staff told us that they communicated regularly with district nurses, practice nurses, social services, occupational therapists and physiotherapists about people's discharges. They added that discharges were sometimes delayed until the appropriate equipment was available in the setting they were going to, this may mean people moving to another area of the hospital to await their discharge.

We were told that there were clinical nurses for older people and frailty who undertake good assessments to help with discharge of people. This service was only available during weekdays. Staff told us that the complex discharge team met every day on the Medical Assessment Unit. It included a social worker who could help with setting up, or restarting packages of care that were required before discharge could be confirmed

We were told that the maternity unit staff worked closely with community midwives, many of whom also worked in the hospital setting sometimes. They discuss complex cases between them and work out, in collaboration with the patient, where best a person should be cared for and how that should be managed.

In some instances we have been told that a lead person has been identified to co-ordinate care when a person is involved with a number of consultants in the hospital and some community services.

Our judgement
People using the Royal Cornwall Hospital receive safe and coordinated care and support.

Where other organisations and health care professionals are involved, effective systems have been/are being developed to ensure interagency support is appropriate and effective.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People said that the staff who look after them are 'really nice' and' wonderful' despite the fact they are so busy. One person added that everyone is lovely, the staff are very busy but I feel I am looked after well. Another said that the staff are busy, there is not enough of them and they do long hours.

Two people we spoke with on Medical Assessment Unit said that the staff are' kind but very busy, one said 'you ask a question but they don't come back' (with the answer). Another person told us that staff do not have enough time to treat you as an individual, you ask for something and they say 'hang on, hang on'.

During our observations on Tolgus Ward we saw that a person rang the bell and it was three minutes before it was answered. The nurse who answered it apologised for the time it took to be answered.

Other evidence
On the Medical Assessment Unit there are 52 beds, six of those are high dependency beds. Staff told us that they expect to discharge home about 15 – 16 people per day. The rest of the people on the unit would usually be transferred to wards within Royal Cornwall Hospital or other hospitals.

On the day of the inspection 'side one' of the Medical Assessment Unit had four trained nurses (one of whom was a bank nurse) and a senior health care assistant and two health care assistant (one of whom was ward based and one was from the bank) on

duty. Overnight there were usually four trained nurses and two health care assistants on duty. Side two had three trained nurses, one assistant practitioner (trainee) and one health care assistant on duty. Overnight the unit was staffed with three trained nurses and two health care assistants.
The high dependency unit had two trained nurses on duty looking after five people and had two trained nurses on duty overnight. Trained nurses we spoke with told us that staffing levels were mostly consistent but that there were good days and bad days as sometimes bank and agency staff were not available to cover shifts. We were told that staff were sometimes pulled off the unit to help, in other areas.

Staff on the main Medical Assessment Unit, side two, who we spoke with said that there were usually two to three trained nurses. They added that there were three today because one was supernumerary due to returning from a period of sickness.

We saw that on the Surgical Receiving Unit there were 29 beds and the average length of stay was 48 hours. Admissions came from the emergency department, GP's and the out patients department for example. Staffing levels were typically, four trained nurses and three healthcare assistants during weekdays. With three trained nurses and two healthcare assistants on duty overnight. At weekends there were three trained nurses and two healthcare assistants on duty during the day and three nurses and one healthcare assistant on duty overnight.

On Tolgus Ward three staff members that we spoke to told us that there were not enough staff, but that they covered each other for holidays or sickness, so that shifts were all covered. One added that they sometimes had to use the hospitals own 'bank staff' service. Another said that very rarely they had to use agency staff. We were told on the day of the inspection that they were short of one healthcare assistant on the ward.

The ward has 33 beds and covers a variety of specialities. We saw on the duty rota that the ward typically had five to six trained nurses and three health care assistants on duty during the day and two trained nurses and two health care assistants, on duty, overnight. We were told that the majority of staff work 12½ hour shifts as that was what they preferred. The staff we spoke to went on to say that they had just had two new health care assistants start on the ward and were expecting a trained nurse to start soon. They added that they also had second and third year student nurses on the ward who did eight week placements with them.

Staff told us that the staffing levels allowed for mandatory training and personal development reviews (one to one meetings) to go ahead as these were important for ensuring the workforce was able to meet people's needs.

Polgooth Ward was reopened some months ago to accommodate an overspill of patients due to a ward being closed at the West Cornwall Hospital. It was initially staffed with agency and bank staff and there were a number of complaints received relating to poor care practices. An experienced ward manager was subsequently appointed and a regular staff team has been developed.
She told us that she felt that they currently had enough staff, morale was good, the team were supportive of each other and there had been no recent complaints. For 20 beds the staffing levels, on the day of the inspection were, three trained nurses (one of whom was the ward manager), two health care assistants, with an extra one coming in

for the afternoon .Overnight there were due to be two trained nurses and one health care assistant on duty .
Staff on duty described how supportive the manager was and they felt able to raise any concerns with her. The Trust when told about this had already recognised the good work that had improved the experience for people using the ward and had included this type of information in the staffing review.

For the staffing review the Trust are using 'The Safer Nursing Care Tool', a nationally recommended tool which assists in defining appropriate nursing numbers based on patient dependency and acuity. Information fed into the tool comes from a variety of sources including numbers of falls, complaints, reportable incidences, compliments, safeguarding issues and sickness levels. Non nursing (band 1 to 4) staffing levels are defined by using the same criteria as for nurses by defining what band of staff should be doing what type of work.

Wheal Agar Ward is a 25 bedded older person's ward. We were told that the staff on duty on the day of the inspection comprised of three trained nurses and five health care assistants, plus a housekeeper. Overnight they expected two trained nurses and two health care assistants to be on duty. Staff told us that they have had to use quite a lot of bank and agency staff recently but that this had improved when more staff were recruited. One staff member told us that there were not enough staff to meet the dependency of the people using the service who have a form of dementia. Another said that staff were often taken off the ward to cover other wards.

The Maternity Unit had recently introduced a new system for working out correct staffing levels and skill mix. It included the community midwives (who work both in the hospital and in the community). The unit manager said that this was still in its early stages and formed part of the Royal Cornwall Hospital staffing review. Staff on the ante natal unit said they normally had two midwives and one health care assistant on duty. They also had student midwives on placement within the unit.

On the delivery suite we were told that staff looked at the rotas on a day to day basis to ensure there was enough cover in place. They said that they had an escalation plan when activity exceeded normal expectations, meaning that they could call on midwives from other areas in the unit to make up the numbers.
Staff told us that a number of trained general nurses had been appointed to work in the delivery suite operating theatres instead of midwives. They were currently on their induction programme and the trainer said that they were all enthusiastic to learn new skills, although most of them came from an operating theatre background. We were told that staff were all interested to see how this would work out in practice.

Operating theatre staff (general theatres) told us that the job evaluation for senior staff had been completed and people knew which jobs they had been matched to. They said that this had initially caused some staff to leave. We were told that two new staff had started recently and they were continuing to recruit staff. One bank nurse spoken to said that she worked regularly in the theatre and had got used to the way they worked. She felt it was good for continuity to have the same staff from the bank.

The theatre deputy manager on duty told us that two new theatres were now in use and they often had to use agency staff to ensure that the operating theatre lists were properly staffed. She added that new operating department practitioners had been

appointed and were currently on their induction programme, moving between theatres to get accustomed to how they all worked. The theatre manager (trauma theatres) said that staffing levels had recently improved, although they were still using agency staff sometimes whilst they continued to recruit more staff.

Nursing and healthcare assistants were supported by housekeeping, catering and administrative staff on each ward or department.

Information from the Trust showed us that they were currently carrying out a 'staffing review' within the Royal Cornwall Hospitals Trust, to assess appropriate staffing numbers for the clinical wards, in their three hospitals. They were using a nationally recognised tool called the 'safer nursing care tool'. The 'tool' defines appropriate staff numbers based on patient dependency and 20 days of information collected from each inpatient area. The information included number of falls, the number of complaints, the number of compliments, the number of safeguarding referrals and sickness levels. The' tool' then identified the number of whole time equivalent staff needed to care for people in specific areas. The tool could also be used to identify how many support workers/health care assistants were required.

Our judgement
People's needs are being met by sufficient numbers of staff. Delays in care and support being given sometimes occur because staff are very busy.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Staff we spoke with told us that mandatory training took place and that personal development reviews (PDR's) had been taking place recently. Not all of the people we spoke to had had a PDR. In some areas we were told supervision took place regularly. One person said that it was sometimes done informally and not written down unless there was a need for some training to be arranged. Another person said that if a training issue came up between an annual PDR this was acted upon and not left until the PDR was due.

The manager of the trauma operating theatres reported that 100% of the PDR's in her department had been completed. Staff on the maternity unit told us that they were nearly 100% completed but sometimes when they were busy they got postponed.

Staff told us that in some areas staff meetings took place and that the minutes were made available for those who were not able to attend the meeting.

One newly trained nurse who was still on preceptorship felt supported in their role. A student nurse spoken with said they felt that there was good mentoring in place for the students. People we spoke to who had been off sick said that they had felt supported when coming back to work and had spent some time in a supernumerary capacity.

People using the service said although the staff were busy they could ask them questions or speak to them if they had any concerns. Relatives we spoke to said they had felt included for example when their relative had returned from the operating theatre.

Staff told us that could speak up at team meetings and that they could approach their ward managers if they had any concerns or questions

Other evidence
Staff felt generally well supported, especially on Polgooth Ward, Tolgus Ward and the Surgical Receiving Unit.
Some wards had started doing a ward/department newsletter. They seemed to be popular and had contributions from their own staff about matters that concerned them or were relevant to them as a group.
.
Staff on some wards we visited said that they had a person in charge of training who ensured staff attended their mandatory training and helped them to access other training that may be relevant to their role.

Medical, nursing and care staff were supported to provide care and support for people using the service by catering, cleaning, administrative and portering staff.

Our judgement
The Royal Cornwall Hospital has systems in place which ensure staff are supported in their role.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: People experience effective, safe and appropriate care and support. Care plans are not consistently completed to ensure that staff know about the care and support required to meet people's needs.	
Maternity and midwifery services	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: People experience effective, safe and appropriate care and support. Care plans are not consistently completed to ensure that staff know about the care and support required to meet people's needs.	
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: People experience effective, safe and appropriate care and support. Care plans are not consistently completed to ensure that staff know about the care and support required to meet people's needs.	
Treatment of disease, disorder or injury	Regulation 9 HSCA	Outcome 04: Care and

	2008 (Regulated Activities) Regulations 2010	welfare of people who use services
	Why we have concerns: People experience effective, safe and appropriate care and support. Care plans are not consistently completed to ensure that staff know about the care and support required to meet people's needs.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: People's needs are being met by sufficient numbers of staff. Delays in care and support being given sometimes occur because staff are very busy.	
Maternity and midwifery services	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: People's needs are being met by sufficient numbers of staff. Delays in care and support being given sometimes occur because staff are very busy.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: People's needs are being met by sufficient numbers of staff. Delays in care and support being given sometimes occur because staff are very busy.	
Surgical procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: People's needs are being met by sufficient numbers of staff. Delays in care and support being given sometimes occur because staff are very busy.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA