CQC Guide

Contents:

- CQC
  - What is CQC?
  - How do they assess us?
  - What are the CQC Standards?
- What does this all mean for clinical services?
- Self-assessment and using the CQC Outcomes
  - PCA and evidence folder general guidance
  - PCA and inspection preparation
- Mock inspections
  - What to expect
  - When the inspectors arrive
  - Following the inspection
  - What does the compliance mean?
  - What happens next?
- Appendices:
  - Appendix 1 – Be Prepared poster
  - Appendix 2 – CQC guidance on PCAs
  - Appendix 3 – SMART Action Plans poster
What is the CQC?

CQC is the national independent regulatory body of health and social care services in England.

Their role is to ensure that care; treatment and support provided by health and social care providers meet the essential standards of quality and safety set out in the Health and Social Care Act (2008)

What does that mean?

Services providing health and social care must register to be able to carry out regulated activities e.g. Personal Care, Nursing Care to specified groups of people e.g. Children, Adults, People with Mental Health Problems and People with a Learning Disability. The service must tell CQC where the service is provided, what it is providing and must declare that that it meets the necessary standards of quality and safety. Services must also be able to provide evidence of compliance when requested to do so by the CQC.

So – how does that relate to staff on the ground?

All staff need to understand the role of the CQC and the requirement to meet their standards at all times. Delivering these standards is a legal requirement for service providers. To assist in understanding these requirements CQC have expanded their advice into more detailed guidance on their expectations – these are known as the Essential Standards of Quality & Safety and are listed on the next page. Staff need to familiarise themselves with these standards and evaluate their practice against them.

How do CQC assess?

- **Scheduled**: these are unannounced inspections that focus on a minimum of five of the national standards, and they’re also tailored to the type of care that is provided at the service.

- **Responsive**: these are unannounced inspections that are carried out where there are concerns about poor care. Most inspections are unannounced

- **Themed**: these inspections focus on specific standards of care or types of care services.
What happens if we don’t meet the standards?

Non-compliance is graded into a number of categories based on the severity of the issue identified and the degree of risk to service users:

- **Compliance action** – ranging from minor to major issues, where action is required in the form of an action plan from the service to rectify issues highlighted.

- **Enforcement action** – the breach is more serious or several continual breaches have been reported – CQC can then use their enforcement powers; warning notices, restricting or suspending a service, issuing fines and formal cautions or in extreme cases; cancelling the providers registration or prosecuting the registered manager or provider..
What are the CQC Standards?

<table>
<thead>
<tr>
<th>No</th>
<th>Standard</th>
<th>Description</th>
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</table>
| 1  | Respecting and involving people  |  ❖ People who use services have their privacy, dignity and individuality respected by staff.  
  ❖ People who use services are informed about their care and are involved in decision making and have their decisions respected |
| 2  | Consent to care and treatment    |  ❖ People who use services understand their care and treatment options are given the opportunity to consent or deny consent where they are able.  
  ❖ Staff understand and respect service user’s choices.  
  ❖ Staff understand when someone is unable to give consent and take appropriate action to ensure that treatment is provided in their best interest – involving someone who knows them. |
| 4  | Care and welfare                 |  ❖ People who use services have their needs identified through thorough assessment.  
  ❖ People who use services have their individual, changing needs met through care/support plans which address their risks, needs and goals in an appropriate time frame.  
  ❖ Risks to people are reduced through response to Patient Safety Alerts and through continuity planning. |
| 5  | Nutrition                        |  ❖ People who use services have their nutrition and hydration needs assessed.  
  ❖ Risks are identified relating to nutrition and plans are in place.  
  ❖ When food and drink is provided as part of care – food is nutritionally balanced and meets the individual and cultural needs of the person. Food and drink is provided regularly and in an accessible way. |
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<th>Description</th>
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| 6  | Cooperating with other providers                  | - Where care is shared or people are being transferred between services, care treatment and support provided is co-ordinated and free from unnecessary delays.  
  - Communication between services occurs in a secure, timely and appropriate manner. |
| 7  | Safeguarding people from abuse                    | - Staff understand different kinds of abuse and neglect and take appropriate action to assess for the signs of abuse. Staff understand how to escalate concerns.  
  - People who use services are provided information about how to identify and report abuse.  
  - Processes are in place to protect people detained under the MHA, those who lack capacity and those requiring restraint. |
| 8  | Cleanliness and infection control                 | - Staff follow policies and procedures regarding infection prevention and control and hand hygiene.  
  - The environment and equipment should be visibly clean and this should be monitored.  
  - Sharps and COSHH should be stored and disposed of appropriately. |
| 9  | Management of medicines                           | - Staff store, handle, prescribe and administer medication in a safe and appropriate way following national guidance.  
  - Service users understand what their medication is for and have the possible side effects explained to them.  
  - Medication information is appropriately recorded, including allergies, missed doses or refusals. |
| 10 | Safety and suitability of premises                | - Service users are seen in safe, accessible surroundings that promote their wellbeing.  
  - Service users, staff and others using the service experience safe, suitable surroundings which are adequately maintained. |
<table>
<thead>
<tr>
<th>No</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
</table>
| 11 | Safety, availability and suitability of equipment | - Equipment is clean, safe, adequately maintained, available for use and fit for purpose.  
- Equipment used is comfortable, meets the needs of the service user and promotes independence.  
- Equipment is only used by suitably trained staff in a safe way following published guidance. |
| 12 | Requirements relating to workers              | - Staff are physically and mentally fit for work and are appropriately skilled and qualified.  
- Effective recruitment procedures are in place and relevant checks are carried out on employment of staff.  
- Staff are registered with appropriate professional bodies or regulators. |
| 13 | Staffing                                      | - There are sufficient numbers of staff to respond to both expected and unexpected changes in circumstances.  
- There is an appropriate skill mix of staff and sufficient numbers of staff who know the service users and service to provide high quality, consistency of care. |
| 14 | Supporting workers                            | - Staff are supported in their health, emotional and professional needs.  
- Clinical staff have clinical supervision; all staff are offered regular 1:1 supervision with their line manager and have yearly appraisals.  
- Staff are supported to undertake training and able to gain further skills and qualifications relevant to their role. |
| 16 | Assessing and monitoring the quality of service provision | - Procedures are in place to monitor the quality of service provision, such as; incident and near-miss reporting, complaints, patient experience surveys, audits and other internal and external assessments.  
- Processes are in place to analyse and learn from adverse events to reduce risks and improve quality of service. |
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| 17 | Complaints | - Service users (or their carers) should have easy access to information about how to make a complaint, should feel their complaint is listened to and acted on, and will not be discriminated against for making a complaint.  
- A system should be in place and staff should respond to, resolve and learn from complaints and comments to improve service provision. |
| 21 | Records | - Records are accurate, fit for purpose, held securely and remain confidential.  
- Records are easily accessible and are updated as soon as practicable. |
What does that mean for clinical services?

CQC can turn up on any day at any time unannounced to any of our clinical services to carry out an inspection. This means that everyone has to have an understanding of what CQC is, what they expect to see and what you can do to make an inspection go smoothly.

The standards (outlined above) give an idea of what the general expectations of CQC are. Largely – services will be meeting these standards as part of their daily working practice. However, CQC will be looking for the proof of this. CQC will look for evidence that services are meeting their standards and have in place a monitoring process to demonstrate compliance with their guidance.

Self-assessment and using the CQC outcomes/standards

The first step is to order a copy of the CQC Essential Standards of Quality and Safety, if you don’t have one already, for your team for reference or you can download a PDF version from the CQC website. Beware printing as this document is very long!

Perhaps make CQC a regular item on the team meeting agenda, share out evidence collection between you, make a CQC quiz – whatever it is – try to ensure all members of the team are involved.

It is useful to have an allocated CQC lead in your team or share across an area. This person should be your allocated “expert” for any queries regarding CQC. If it is practical, this person could also be responsible for your CQC evidence folder.

The Trust recommends that all services have a CQC evidence folder. This evidence folder should be based on your Provider Compliance Assessment (PCA) or equivalent. This can be electronic or paper, but however it is stored all staff should have access and know where it is kept.

The PCA is a document where you declare your compliance against each of the outcomes. Your evidence folder should have a section for each of the outcomes/standards – see the next section for more detailed guidance on what evidence to use.

You should have a schedule to review and update your PCA and evidence folder – we recommend four outcomes per quarter. Your service should have a process for self-assessment using tools such as the matron walk-round or audits, and should act on any issues found – all of this is great evidence for your folder.
• Keep your PCA in the same place as the evidence and refer to the relevant evidence when judging compliance.

• Remember – ALL 16 main outcomes apply to everyone – don’t assume one doesn’t apply to you.

**Do**

• Have audit tools, schedules, results and action plans – under the relevant outcome per topic.

• List or link to the relevant policy or procedure on the Trust website under each outcome.

• Take pictures of leaflet racks or put in a list of information taken into people’s houses.

**Don’t**

• Put blank audit tools in outcome 16 with no results, schedule or actions.

• Print out policies in full or save a version to your own drive – this will soon be out of date.

• Put leaflets on their own into the folder – this is not proof that you give them out!

**Below** you can find detailed information about what evidence can be collected against each outcome. Also there is some information about what would be expected on an inspection against each outcome.
## PCA and Inspection Guidance for Services

<table>
<thead>
<tr>
<th>CQC Outcome</th>
<th>Health and Social Care Act Regulation</th>
<th>Description</th>
<th>Examples of Written Evidence (not exhaustive)</th>
<th>Examples of Evidence on Inspection (any of the previous column may also be requested for review)</th>
</tr>
</thead>
</table>
| 1           | 17                                    | Respecting and involving people who use services | • Patient Experience survey results and actions taken  
• Audit of care plans/support plans/treatment plans including checks of service users being given copies.  
• Minutes of service user groups  
• Complaints, comments, compliments including actions taken and evidence of discussions within the team.  
• Equality and diversity training records | • Observations of staff actions  
• Patient surveys available  
• Service user records demonstrate service user involvement  
• Asking service users if they have been involved and had treatment plans explained  
• Observe that service users are encouraged to be independent and participate in activities.  
• Information should be available for service users relating to the service and their rights. |
| 2           | 18                                    | Consent to care and treatment | • Audit of permission to share and/or consent forms or evidence of verbal consent in records and/or DNACPR forms  
• Consent and consent to share procedures  
• Case conference, best interest and/or discharge planning meeting notes. | • Consent to share, consent to treatment and/or mental capacity assessments present in service user records where necessary.  
• Information given to service users in an appropriate, understandable way.  
• Staff and service users understand consent and right to refuse. |
<table>
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</thead>
</table>
| 4           | 9                                    | Care and welfare of people who use services | • MDA/PSA information – written cascade route and actions taken.  
• Sample letters/information about the service giving contact details and staff names.  
• Spot checks ensuring staff wear ID badges  
• Assessment, care/treatment/support plan, risk assessment, end of life care record keeping audits and actions.  
• Risk procedures  
• Emergency planning procedures  
• Triaging procedures  
• Equality and Diversity training records.  
• Environmental assessments and actions taken including single sex accommodation. | • Service user records demonstrate assessments and appropriate, individualised and detailed care/treatment/support plans in place and up to date.  
• Staff introduce themselves and wear ID badges  
• Staff explain treatment in a way appropriate to the service user  
• Staff involve service users and offer choices  
• Risk assessments and emergency planning documentation is in place.  
• Contact details for the service given to service user.  
• Plans in place for when service user’s needs change.  
• Diversity and individual needs are established and respected.  
• Children are involved in decision making where appropriate.  
• Service users seen in an appropriate environment.  
• End of life documentation demonstrates full service user involvement and have thorough plans in place. |
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</table>
| 5           | 14                                   | Meeting nutritional needs | • Procedures e.g. protected meal times.  
• Audits of records including MUST assessments, Fluid intake charts, height/weight measurements and care plans and referrals where needed.  
• End of life documentation  
• Food Handling training records  
• Menu choice information  
• Patient Experience Survey results relating to food  
• Training records. | • Staff are aware of policies and procedures.  
• Records with identification of nutritional needs and appropriate assessment and care planning.  
• Speaking to service users – if they are offered choices relating to food, if they are happy with the quality of the food and if food is available between meal times.  
• Appropriate referrals made in a timely manner.  
• Protected meal times.  
• Observing staff ensuring service users have access to food and drink. |
| 6           | 24                                   | Cooperating with other providers | • Emergency planning procedures linking with other providers where necessary.  
• Discharge/referral information – available services or service user pathways.  
• MDT meetings minutes/schedule  
• GP meetings minutes/schedule  
• Case Conference notes  
• Discharge Planning meeting notes  
• Audit of letters to other professionals  
• Procedures relating to sharing information  
• Permission to share form reviews. | • Care co-ordinator identified where multiple professionals are involved in providing care.  
• Multi-agency plan of care in place.  
• Staff aware of policies and procedures. |
<table>
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</table>
| 7           | 11                                     | Safeguarding vulnerable people who use services | • Safeguarding meeting minutes  
• Safeguarding training records  
• Safeguarding posters/leaflets and how the information is made accessible.  
• Safeguarding team contact details – evidence that staff can access these and are aware of them.  
• Safeguarding reporting procedure  
• Team meeting minutes demonstrating discussion of vulnerable service users.  
• Review of capacity assessments and best interest meeting minutes  
• DOLS documentation review  
• MHA training, restraint training and audits of MHA paperwork. | • Staff aware of policies and procedures and escalation route.  
• Contact details available for staff.  
• Leaflets available for service users about identifying and reporting abuse.  
• Appropriate assessments and action taken when concerns are identified. |
| 8           | 12                                     | Cleanliness and infection control | • Infection control, hand washing and cleaning audits with appropriate actions.  
• Signage  
• Infection control and cleaning procedures | • Observation of staff following correct infection control procedures.  
• Signage in place.  
• Sharps procedures in place.  
• Visibly clean and tidy environment.  
• Hand cleaning and equipment cleaning facilities available and practical to use. |
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<tbody>
<tr>
<td>9</td>
<td>13</td>
<td>Management of medicines</td>
<td>• Policies and procedures.</td>
<td>• Observation of medication administration.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Audits of medication storage and controlled drugs with actions taken.</td>
<td>• Observation of medication storage facilities.</td>
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<tr>
<td></td>
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<td></td>
<td>• Drug fridge monitoring forms</td>
<td>• Service users are given information about their medications.</td>
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<td></td>
<td>• Prescription guidance</td>
<td>• Medication history and allergies are requested and recorded.</td>
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<td></td>
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<td></td>
<td>• Team meeting minutes demonstrating discussion of medicines issues.</td>
<td>• Drugs charts completed correctly with no omissions.</td>
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<td></td>
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<td></td>
<td>• Review of records in relation to recording of allergies, administration of medication and medication history</td>
<td>• Medication is disposed of correctly.</td>
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<tr>
<td></td>
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<td></td>
<td>• Incidents involving medications and actions taken.</td>
<td>• Side effects are recorded and reported if appropriate.</td>
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<td></td>
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<td></td>
<td>• Training records for medicines management and for any nurse prescribers.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>15</td>
<td>Safety and suitability of premises</td>
<td>• Ligature assessments (if applicable)</td>
<td>• Premises are clean, well maintained and fit for purpose.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Environmental risk assessments</td>
<td>• Staff are aware of policies and procedures.</td>
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<td></td>
<td>• Single sex accommodation</td>
<td>• Single sex accommodation is maintained.</td>
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<td></td>
<td>• Maintenance and estates requests.</td>
<td>• Appropriate signage in place.</td>
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<td></td>
<td></td>
<td></td>
<td>• Photographs of signage</td>
<td>• Privacy and dignity is maintained.</td>
</tr>
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<td></td>
<td></td>
<td>• Security checks and procedures</td>
<td>• Fire and Health and Safety regulations being met.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Fire and Health and Safety Procedures and any relevant checks.</td>
<td>• Appropriate office, clinical and storage space available.</td>
</tr>
<tr>
<td>CQC Outcome</td>
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</tbody>
</table>
| 11          | 16                                    | Safety, availability and suitability of equipment | • Equipment inventory  
• Equipment service/maintenance schedule  
• Equipment cleaning and servicing procedures  
• Staff training records  
• MDA/CAS alert record and actions taken. | • Staff are adequately trained and competent to use equipment that they use.  
• Equipment is well maintained, readily available, suitable for purpose and clean.  
• Equipment used protects service user privacy and dignity and promotes independence.  
• Staff are aware of policies and procedures.  
• Equipment used fits with the care plan and is agreed by the service user. |
| 12          | 21                                    | Requirement s relating to workers                | • Recruitment and selection procedures.  
• Staff personal files evidence required qualifications, professional registration, references and CRB checks.  
• Fitness to practice concern reporting routes. | • Staff are physically and mentally fit to work.  
• Personal files – evidence as in evidence column. |
| 13          | 22                                    | Staffing                                         | • Staffing level reviews or discussions in team meeting minutes about levels and skill mix of staff.  
• Overtime arrangements.  
• Emergency planning procedures for staff.  
• Staff competencies and training records. | • Observation and discussion of staffing levels including vacancies, sickness and maternity leave.  
• Staff files and training records.  
• Staff competency records.  
• Emergency plans. |
<table>
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</tr>
</thead>
</table>
| 14          | 23                                    | Supporting workers | • Local induction information.  
• Training records.  
• Clinical supervision records  
• Supervision and appraisal records.  
• In-house training  
• Job descriptions and person specifications.  
• Lone working policy and emergency contact details present for all staff.  
• Team meeting minutes  
• Staff satisfaction surveys  
• Occupational health assessments.  
• Sickness procedures.  
• Bullying, harassment and whistleblowing policies. | • Staff feel supported in the provision of care.  
• Staff are offered training and career development opportunities.  
• Staff are aware of bullying, harassment and whistleblowing procedures and feel confident to raise any concerns.  
• Staff feel they are supported in their health needs.  
• Evidence as discussed in evidence column. |
| 16          | 10                                    | Assessing and monitoring the quality of service provision | • Reviews of risk assessments.  
• Evidence of discussion of complaints, comments and compliments and appropriate action plans in response.  
• Evidence of discussion of incidents and near misses and action plans in response.  
• Procedures for reporting incidents and handling complaints.  
• Audits and audit schedule with responsible staff members named and action plans in response to issues found. | • Staff should be aware of how to report and incident or near miss and the correct complaints procedure and should be able to demonstrate this is done correctly.  
• Staff should be aware of how to access policies and procedures.  
• Evidence should be available that the team is monitoring quality and learning from issues found. |
<table>
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</thead>
<tbody>
<tr>
<td>17</td>
<td>19</td>
<td>Complaints</td>
<td>• Complaints procedures.</td>
<td>• PALS and Complaints leaflets in evidence and readily available to service users.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Complaints received and evidence of discussion and actions taken.</td>
<td>• Team meeting minutes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• PALS and Complaints team leaflets.</td>
<td>• Staff are aware of complaints procedures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Observation of staff handling comments, compliments or complaints.</td>
<td>• Observation of staff handling comments, compliments or complaints.</td>
</tr>
<tr>
<td>21</td>
<td>20</td>
<td>Records</td>
<td>• Record keeping policies or procedures.</td>
<td>• Observation that records are stored logically, securely and in a way which is easily accessible for staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Record audits and action plans in response.</td>
<td>• Confidentiality is maintained – for example computers are locked and smartcards removed when leaving computers unattended.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Incidents relating to records and discussions and actions taken.</td>
<td>• Records are updated in a timely manner by appropriate staff members and any student entries are countersigned.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Information governance training records.</td>
<td>• Paperwork in files is organised logically so that information can be easily located.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Archiving and disposal records.</td>
<td>• Records should be archived and disposed of appropriately.</td>
</tr>
</tbody>
</table>
Mock Inspections

The Mock Inspections are unannounced visits to all sites (including community teams) to assess how compliant they are against CQC standards. As with the “real” CQC services will not know in advance that an inspection is going to take place or which CQC standards they will be assessed against.

What to expect

The Mock Inspectors will behave in a similar way to CQC inspectors. They will ask questions to assess services against the same standards and have the authority to be able to ask staff for any documentation they may have.

Mock Inspections will be either;

A peer review team from your own Division and could also include representatives from other Divisions as well. Frequency of these inspections will be determined by the Division and may be part of a regular programme or responsive/risk based following concerns being raised.

A team coordinated by the Quality & Governance Team which would include representatives from the Division being inspected and others from across the organisation. This would only be as a responsive/risk based inspection following concerns being raised.

What does compliance mean?

The quality and governance team have created a “compliance calculator” to help the inspectors to judge compliance consistently – you can see this over the page. This follows CQC’s pattern of compliance and non-compliance. Services will be judged either:

- Compliant
- Non-compliant – minor concerns
- Non-compliant – moderate concerns
- Non-compliant – major concerns

If major concerns are found – these will always be escalated immediately to the Divisional Director.

If a moderate concern is found the lead inspector should notify the Divisional Director to make them aware of the concerns and ensure they are addressed promptly.

The inspection should highlight good practice and feed this back to the team. Any action plans required to take suggested improvements forward will be monitored by the Divisions own internal quality assurance processes.
### Compliance and severity calculator

<table>
<thead>
<tr>
<th>Likelihood of event happening</th>
<th>Potential impact on service user and/or staff safety (worst case)</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unlikely</strong></td>
<td>Worst case – low impact Unlikely that this will happen/process is otherwise robust</td>
<td>Worst case – moderate impact Unlikely that this will happen/process is otherwise robust</td>
<td>Worst case – high impact/ catastrophic outcome Unlikely that this will happen/process is otherwise robust</td>
<td><strong>No recommendation</strong> needed – advise staff verbally on the day.</td>
</tr>
<tr>
<td><strong>Possible</strong></td>
<td>Worst case – low impact Possible this will happen as process not fully robust</td>
<td>Worst case – moderate impact Possible this will happen as process not fully robust</td>
<td>Worst case – high impact/ catastrophic outcome Possible this will happen as process not fully robust</td>
<td>Recommendation in report</td>
</tr>
<tr>
<td><strong>Likely/ingrained</strong></td>
<td>Worst case – low impact Likely this will happen due to ingrained poor practice/ poor procedures</td>
<td>Worst case – moderate impact Likely this will happen due to ingrained poor practice/ poor procedures</td>
<td>Worst case – high impact/ catastrophic outcome Likely this will happen due to ingrained poor practice/ poor procedures</td>
<td>Recommendation in report</td>
</tr>
<tr>
<td><strong>Observed behaviour/ known to happen</strong></td>
<td>Worst case – low impact Observed impact during inspection or known to have occurred (from staff or intelligence collection)</td>
<td>Worst case – moderate impact Observed impact during inspection or known to have occurred (from staff or intelligence collection)</td>
<td>Worst case – high impact/ catastrophic outcome Observed impact during inspection or known to have occurred (from staff or intelligence collection)</td>
<td>Recommendation in report</td>
</tr>
</tbody>
</table>

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**Compliance and severity calculator**

- **Low**: Unlikely to happen, process is robust. No recommendation needed. Advise staff verbally.
- **Medium**: Unlikely to happen, process needs improvement. Recommendation in report. Minimal re-visit.
- **High**: Unlikely to happen, process needs urgent attention. Recommendation in report. Escalate via email to Divisional Director. Minimal re-visit.

**Likelihood of event happening**
- **Unlikely**: Likely to happen, but unlikely to cause significant harm. No recommendation needed. Advise staff verbally.
- **Possible**: Possible to happen, process needs improvement. Recommendation in report. Minimal re-visit.
- **Likely/ingrained**: Likely to happen due to ingrained poor practice. Recommendation in report. Escalate via email to Divisional Director. Minimal re-visit.
- **Observed behaviour/ known to happen**: Observed impact during inspection or known to have occurred. Recommendation in report. Escalate via email to Divisional Director immediately. Re-visit category.**
A record of the recommendations and best practice found will be themed under the following themes. This information will be available for inclusion in Divisional and corporate reports.

<table>
<thead>
<tr>
<th>Outcome 1: Respecting and Involving people</th>
<th>Service User Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Service User Information</td>
</tr>
<tr>
<td></td>
<td>Service User Privacy and Dignity</td>
</tr>
<tr>
<td></td>
<td>Staff Attitude</td>
</tr>
<tr>
<td>Outcome 2: Consent to care and treatment</td>
<td>Consent to Care/Treatment</td>
</tr>
<tr>
<td>Outcome 4: Care and Welfare</td>
<td>Assessing and reducing risks to service users</td>
</tr>
<tr>
<td></td>
<td>Meeting Individual needs</td>
</tr>
<tr>
<td>Outcome 5: Meeting Nutritional Needs</td>
<td>Nutrition</td>
</tr>
<tr>
<td>Outcome 6: Cooperating with other providers</td>
<td>Communication</td>
</tr>
<tr>
<td>Outcome 7: Safeguarding people</td>
<td>Safeguarding Awareness/Training</td>
</tr>
<tr>
<td></td>
<td>Safeguarding Procedure</td>
</tr>
<tr>
<td>Outcome 8: Cleanliness and infection control</td>
<td>Cleanliness/Infection Control</td>
</tr>
<tr>
<td>Outcome 9: Medicines management</td>
<td>Medicines Management</td>
</tr>
<tr>
<td>Outcome 10: Safety and suitability of premises</td>
<td>Safety/Suitability of Premises</td>
</tr>
<tr>
<td>Outcome 11: Safety, suitability and availability of equipment</td>
<td>Safety/Suitability of Equipment</td>
</tr>
<tr>
<td>Outcome 12: Requirements relating to workers</td>
<td>Requirements relating to workers</td>
</tr>
<tr>
<td>Outcome 13: Staffing</td>
<td>Staffing Levels/Suitability</td>
</tr>
<tr>
<td>Outcome 14: Supporting workers</td>
<td>Supporting Workers</td>
</tr>
<tr>
<td></td>
<td>Staff Training</td>
</tr>
<tr>
<td>Outcome 16: Assessing and Monitoring quality</td>
<td>Awareness of CQC</td>
</tr>
<tr>
<td></td>
<td>Monitoring Quality</td>
</tr>
<tr>
<td>Outcome 17: Complaints</td>
<td>Complaints</td>
</tr>
<tr>
<td>Outcome 21: Records</td>
<td>Access to IT</td>
</tr>
<tr>
<td></td>
<td>Information Governance</td>
</tr>
<tr>
<td></td>
<td>Service User Records</td>
</tr>
</tbody>
</table>
Be prepared!

Care Quality Commission (CQC)

Unannounced Visits

Who are CQC

The Care Quality Commission (CQC) is the health and social care regulator for England. They are responsible for monitoring the standards that services must achieve and will inspect periodically to check staff & services are meeting those standards.

CQC could arrive at any of the Trusts services, unannounced, at any time.

What to do if CQC arrive at your work base

- They should introduce themselves and show identification—if not, ask to see it;
- Let them know who the person in charge is and introduce them;
- Ensure that Trust HQ are informed that CQC are on site
  Call the Governance Team immediately on 023 80 87 4036 and also inform your Divisional / Area Director and/or Manager
- Make them welcome and offer them a place to work from;
- Be open and honest with the inspector and give them all the information they request

How the visit may look

The inspectors will
- have looked at all the information they already hold on the service prior to their visit (e.g. incidents, complaints, staff/patient surveys) and will use this to triangulate with what they see in practice
- have selected the Outcomes they wish to inspect and will inform staff
- select the clinical areas they wish to inspect:
  - ask to speak to various leads about corporate compliance;
  - spend several hours observing practice, viewing records and talking to patients and staff of all levels;
  - speak to several people about the same thing to validate what they are being told

What will they expect?

- To be allowed access to the information they require and the people they would like to speak to;
- Information/evidence is current (up-to-date), available, easy to read and available locally to demonstrate compliance;
- There is an internal quality reviewing process in place

What you need to know

- Who CQC are and have an overview of the essential standards of quality and safety;
- Who your local CQC lead is;
- Where your service’s Provider Compliance Assessment (PCA) and folders of evidence are held;
- How to access policies and procedures

CQC inspections are an opportunity for you to show and tell the CQC the work you are doing and receive feedback from them.

For more information please contact:
Arthur Green - Compliance Manager
Tel: 023 8087 4036
Email: arthur.green@southernhealth.nhs.uk
A new system of registration

Provider Compliance Assessment
Guidance for providers

September 2010
Introduction

This guidance explains the purpose of the Provider Compliance Assessment and how and when it can be used. It includes:

- Tips on how to complete it.
- How to document the improvements needed.
- How to complete the analysis of evidence sections.
- What to do if we ask you to submit part of the Provider Compliance Assessment.

Main points

In order to support registered providers in their ongoing compliance with the outcomes described in the Guidance about compliance: Essential standards of quality and safety, we have developed a self-assessment tool called the Provider Compliance Assessment (PCA).

It is not mandatory for providers to routinely use or complete the PCA, but we encourage you to use it as it will be helpful when assessing your compliance on an ongoing basis.

We may ask you to submit some or part of the PCA when we are carrying out a review of compliance (either planned or responsive). Where you collate evidence to demonstrate compliance in a format that is different from the PCA, you must submit such evidence, within the specified timeframe, when we ask for it.

The PCA focuses on outcomes for the 16 key essential standards most directly related to the quality and safety of care. These are set out in part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

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

To help you complete the PCA more easily, we have split the document into 16 files, one for each regulation and associated outcome.

Each PCA should relate to **one** location only.
1 What are the key differences between the assessment process for registration and the process for monitoring of compliance?

During the registration process, you were required to declare compliance for each regulated activity at each of your locations. The approach for monitoring of compliance differs slightly from this: you will be required to demonstrate compliance across the whole of the service at a location level.

In addition, while you were only able to assess yourself as compliant or non-compliant at registration, the process for monitoring of compliance will allow you to:

- Identify those areas where you have varying levels of concerns about non-compliance to certain outcomes.
- Develop action plans that state what you are going to do about shortfalls, in a timely manner, to ensure that people who use services experience the essential standards of quality and safety.

2 The purpose of the Provider Compliance Assessment

The PCA has been designed as a self-assessment tool for you to monitor your compliance with the essential standards of quality and safety.

You can use it as a routine internal assurance tool, or as an ad hoc assessment in response to specific concerns. It is not mandatory for you to use or complete this document.

The PCA is available on our website. It is split into 16 different files, one for each of the key quality and safety standards and associated outcomes.

The PCA should be used alongside the Guidance about compliance; Essential standards of quality and safety and it is aligned to the Guidance about compliance: Judgement framework.

3 How and when the Provider Compliance Assessment can be used

You can use the PCA on a regular basis to self-assess if you wish. You can use it to provide assurance that you are compliant with the outcomes for the essential standards of quality and safety. The PCA should be completed at location level and not for each regulated activity. To this end, you will only be required to complete one PCA per location.
You can use it on an ongoing basis. Keeping it up to date will ensure that the information is current and readily available.

Where we have gaps in the information we hold about a regulated activity at specific locations, we may ask you to send us parts of the PCA. This may be when we are doing a planned review of compliance, or responding to concerns.

Each of the outcomes stands alone. When an inspector or assessor needs more information, they will ask you to submit the outcome sections they need more information about, rather than over-burdening you with requests for information they do not need.

To arrive at a robust judgement, our inspectors and assessors always cross-reference or ‘triangulate’ data with information from several other sources where possible. This involves gathering information through more than one method, such as talking to people who use services, using surveys or making direct observations of care during a visit.

4

How to complete a Provider Compliance Assessment

The outcomes in the PCA are reproduced from the guidance about compliance documents: Essential standards of quality and safety and the Judgement framework. You should read the guidance about compliance in detail to ensure that each outcome is fully addressed.

You can mark the green, yellow, amber and red assessment boxes to document your assessment against each outcome statement. This is the same colour-coded system as that used in the Judgement framework.

- **Evidence available at the time of assessment shows that the outcome is met.**

- **Evidence available at the time of assessment shows that the outcome is mostly met, or there is not sufficient evidence to demonstrate that the outcome is met. The impact on people who use services, visitors or staff is low. The action required is minimal.**

- **Evidence available at the time of assessment shows that the outcome is mostly met, or there is not sufficient evidence to demonstrate the outcome is met. The impact on people who use services, visitors or staff is medium. The action required is moderate.**

- **Evidence available at the time shows that the outcome is at risk of not being met or there is no available evidence that the outcome is met. The impact on people who use services, visitors or staff is high. Action is required quickly.**
The definitions of ‘impact’ are:

**Low:** No or minimal level of impact on people who use services in one or more areas.

**Medium:** A moderate impact, but no long-term effects on people who use services in one or more of the areas.

**High:** A significant or long-term impact on people who use services in one or more of the areas.

If any areas are assessed as red, amber or yellow, there are sections at the end of each outcome to record any action plans needed to improve services. See below for information about writing action plans.

### How to complete the summary of evidence sections

For each prompt, record in the summary of evidence section the evidence that demonstrates the outcome is being met for people who use the service. For more detailed guidance on the types and sources of outcome evidence, please refer to our guidance document *Using evidence of outcomes to demonstrate compliance*, which is available on our website.

You should use the most appropriate evidence available to demonstrate that the outcome for people who use the service is met. Where appropriate, evidence can be cross-referenced across prompts.

It is also important that, as far as possible, the evidence you use:

- Covers all of the services provided at the location.
- Is current and accurate.
- Relates to all groups of people who use the service and takes account of diversity.

If the regulation and outcomes for people using the service are met in an innovative way, not listed in the guidance about compliance, this is equally relevant and should be included in the analysis of evidence box.

You can use any evidence that shows the impact that care treatment and support have on people, to help demonstrate outcomes. Therefore, evidence of outcomes can use both quantitative and qualitative measures, such as: clinical data; feedback from people who use the service and people acting on their behalf; feedback from staff members; evaluation of skills and competence; monitoring use of good practice; measuring satisfaction; monitoring risks; implementing learning or monitoring action plans.

You should aim, as much as possible, to focus on evidence that:

- Comes directly from people who use services and those acting on their behalf.
• Relates to individual’s experiences and needs.
• Relates to risks to the health, welfare and safety of individuals.
• Demonstrates how concerns are addressed and how feedback has been listened to and acted on.

Evidence directly from people who use services and those acting on their behalf could include:

• Survey results.
• Complaints and comments from individuals.
• Patient reported outcome measures (PROMS).
• Feedback from specific groups of people.
• Feedback from the public.
• Focus groups and other involvement activities.
• Local Involvement Networks (LINks).
• Patient Advice and Liaison Service (PALS).

Other evidence that may demonstrate outcomes for people directly or indirectly could include:

• Actions and improvements resulting from people’s feedback.
• Staff survey results and feedback and outcomes reported by staff.
• Internal and external reviews of services.
• Audits, including clinical audits and action plans developed and addressed as a result of audit.
• Effective risk assessment and management.
• Individual care records, which may demonstrate assessment, planning, review and evaluation.
• Individualised needs assessments.
• Staff skills and competence.
• Incident reports, learning and improvement actions.
• National and local data sets and comparative information.
• Equalities data and evaluations.
• Assessments from other regulatory bodies, inspections or accreditation schemes.
How to document the improvements needed

There are sections at the end of each outcome area to record any action plan for any improvements needed and how they will be addressed.

You should put the number of the outcome area assessed as yellow, amber or red (for example, 1A or 6G) in the ref. number box at the top of the table.

To be robust, action plans should use the “SMART” technique:

- **Specific** – identify the details of the area that needs to be improved, and what action needs to be taken. Say explicitly what is to be achieved, and who is going to make the changes.
- **Measurable** – say how you going to ensure that improvements have been made. What measures are going to put in place and who will do it?
- **Achievable** – check that the measures to be put in place are achievable, attainable and sustainable.
- **Realistic** – describe the resources needed to implement the changes and whether or not they are in place.
- **Time-bound** – give an appropriate date by which the improvements will be made and how this date will impact on people who use the service.

What to do if we ask for the completed Provider Compliance Assessment

If an inspector decides that they would like you to provide information, as part of a planned or responsive review of compliance, they will send you an email or a letter asking for the relevant section(s) of the PCA. You will have five working days to submit this information.

You should email the requested parts of the PCA to us.

Do not send any additional evidence with the PCA. The analysis of evidence boxes should contain sufficient information to support their assessment.

After we have read the PCA, we may ask you for further information or specific evidence referred to in the PCA.
## Creating SMART Action Plans

### Specific
**Action** — does the action describe HOW you will achieve an outcome in detail?

### Measurable
**Evidence** — can you provide evidence that the action is complete and the outcome achieved?

### Achievable
**Outcome** — are you able to achieve the outcome following completion of the actions?

### Relevant
**Action** — are the actions going to improve the issue raised?

**Scope** — does the action apply to all relevant people?

### Timely
**Deadline** — realistically, when can the actions be completed by?

#### Poor quality action plan

<table>
<thead>
<tr>
<th>Issue Raised</th>
<th>Theme</th>
<th>Action</th>
<th>Scope</th>
<th>Evidence</th>
<th>Outcome</th>
<th>Accountable Lead</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTCOME 4</td>
<td>Care plans and risk assessments need to be more detailed</td>
<td>Staff to complete care plans and risk assessments in more detail.</td>
<td>Team</td>
<td>Care plans and risk assessments</td>
<td>Detailed records</td>
<td>Joe Bloggs</td>
<td>10.7.12</td>
</tr>
</tbody>
</table>

#### Improved action plan

| Care plans and risk assessments need to be more detailed | Care and Welfare | In-house training session to take place. Random sample weekly spot check of care plans and risk assessments to review quality for one month. Objectives to be set in supervision sessions for improvements if necessary. Audit to be carried out in May to assess quality. | Clinical Staff in the team | Audit results and supervisions records | All care plans and risk assessments to be adequately detailed to ensure continuity and individuality of care and reduce risks to service users. | Joe Bloggs | 10.7.12 |