



# Practice Guidance for Writing Inspection Reports, Priority Action Notices and Outcome statements

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## 1. Introduction

This document provides guidance on writing inspection reports and priority action notices. It should be read in conjunction with the relevant inspection framework for the service area and CIW's [writing style guide](#) and our guide on [Use of Language](#).

We write our reports for the public; assume our intended audience is a lay person with a general interest in social care or childcare, but with no knowledge of specialist terms and abbreviations. Our reports must inform people who use and choose services, and their families, about the quality of care and support provided. We should be clear, concise, avoid jargon and use plain language.

Always consider: *will the content of this report make sense to a lay person?*

Our reports are based on the evidence collected through inspection activity and recorded in the planning and analysis document. The amount of evidence we gather is only ever a small amount of all the information available about a service. When writing the inspection report it is essential we select the strongest evidence we have to support our findings and that it is relevant and accurate. We do not include lots of detail. Any additional evidence is captured in the inspection record or in the priority action notice where applicable.

Some childcare and play settings are inspected jointly by CIW and Estyn. There is separate report writing and style guidance for these inspections.

## 2. People's experience

People's experiences of services should be at the heart of our reports including the impact a service has on their well-being, i.e. outcomes for people.

The report should record our evaluation of the service, in a fair and concise way.

## 3. Summary

Primarily, the summary should be an evaluative analysis that clearly informs people of our findings using concise well-structured sentences.

You may include a short sentence to describe the service – for example its location and stated purpose. Do not name the responsible individual/registered provider or the manager.

Provide an overview of the ratings awarded for each theme.

See examples in the [appendix](#)

In exceptional circumstances, if we have taken enforcement action between inspections, such as imposing an urgent condition on a registration, we can tell the public about it here. If there has been a change in ratings awarded since the last inspection, this can be highlighted here with a brief rationale for the change. Where

we have issued a statutory notice, we would only talk about this in an inspection report if the appeals process has ended.

*Example: In November, we had significant concerns about infection control practices at the service; the rating awarded for Environment at that time was 'Requires significant improvement'. We took urgent enforcement action, and found at this inspection, the provider had made significant improvements, and the Environment is now rated as 'Good'.*

The summary should be **no longer than 200 words**.

## 4. Themes

Each theme should be **no longer than 400 words**; exceptions can be made where it is necessary to provide more detail about an aspect of the service.

We generally report on four themes, although this will depend on the service being inspected. For domiciliary support services, the 'environment' theme will not appear in the report template.

## 5. Key areas / lines of enquiry

In your report, for childcare and play services you will need to answer the **key areas** and for adult and children's services summarise findings in relation to **lines of enquiry** you have considered at inspection (as set out in the relevant frameworks) and then provide the supporting evidence.

You do not need to repeat each key area / line of enquiry in the text, just answer in an evaluative way and provide the evidence to support your findings.

## 6. Information security

Welsh Government has policies, procedures and training courses to ensure we handle sensitive information about people securely. It is your responsibility to ensure that you comply with these. Take care not to identify people using services when writing your report. Ensure you remove any names or identifying narrative in order to avoid data breaches.

If the service only accommodates / provides a service for one person or child at the time of the inspection, continue to talk about 'people' / 'children' / 'young people' receiving services when writing the report.

## 7. Active not passive voice

The active voice is nearly always more direct and clearer than the passive voice. It also conveys more clearly, who is responsible for a situation or action you are writing about. Always put the doer of the action at the front of the sentence. Rather than writing '*people are assessed by care staff before receiving a service*', instead write '*care staff assess people ...*'

Sometimes, the passive voice is useful, so this is not a blanket rule. However, you should be aware of how you use the passive voice and know why you are using it.

Tip: Switch on '*grammar and style*' in word (*file – options – proofing – writing style*) as this will let you know when you have used the passive voice.

## 8. Short sentences and paragraphs

Keep sentences short – 15-25 words should be sufficient for each sentence. Often, the longer the sentence or paragraph, the more complicated it is for a lay reader. Usually, it is only a matter of creating two or three clearer sentences out of one over-complex sentence.

## 9. Simple language

People need to understand what you have written, quickly and easily. That is why it is important to follow the principles of 'Plain English' or 'Cymraeg Clir'.

When writing about a complex issue, it is even more important that the language you choose is as straightforward as possible. It can be helpful to read it aloud to hear how your report sounds.

Tip: You can use the *text to speech function* to read sections of the report aloud to you to see if it makes sense.

## 10. Font

Font size should be **Arial 12 point, 1.15 spacing** and left justification.

Use double line spacing for paragraphs.

## 11. Giving advice

In the body of the report, you should avoid giving advice over and above what is set out in regulations / statutory guidance (Adults & Childrens Services only) / National Minimum Standards (Childcare & Play only). For example, avoid using phrases like '*the service would benefit from...*' This does not stop us telling providers about best practice or signposting to guidance during an inspection visit.

## 12. Use of Terminology

In adult and children's services, we talk about '**services**'. In childcare and play we talk about '**settings**' - we can also use 'nursery', 'crèche' and open access as appropriate.

Use people / children **not** 'service users', 'individuals' or 'cases'.

In adult and children's services, refer to staff as 'care workers' or 'care staff' – never 'carers' as this can be confused with 'unpaid', 'informal carers'.

In childcare and play, depending on the type of service, you may refer to 'play staff', 'nursery staff' etc. but where necessary, you must make the distinction between staff providing care and other workers.

Remember the staff group may be wider than people providing care. It is important to be clear whom you are writing about.

We should always talk about **strengths** as well as areas for improvement and write in a positive manner where appropriate.

*'There are no planned activities on two days of the week'*

Consider instead,

*'There are planned activities on five days of the week'*

We are saying the same thing – but the second sentence is strengths based and more balanced.

Take care not to set out strengths in such a way as to make it appear we endorse one approach only, or that one commercial scheme or product is particularly effective. For example, talk about building blocks not 'Lego', talk about the stair lift not the 'Stannah'. However, reports can reference Welsh Government schemes and initiatives.

## 13. Tenses

Write your report in the present tense as if describing and evaluating the setting now, as in 'people **are** happy and content', 'managers support staff well and listen to staff' and 'children make good progress in language skills'.

Nursery staff **treat** people well...not *treated*, nursery staff promote children's health adequately...not *was promoted*, people **are** listened to and **are given** opportunities to share their opinions during meetings ...not *were / were given* and people **enjoy**...not *enjoyed*.

However, if it is clear that events occurred in the past, then the past tense is appropriate, as in 'The previous inspection *was* in 2010'; or 'we *looked* at...' 'a child *told* us...' Keep in mind we are talking about what we found/saw/read (past tense) to

help us make a judgement about how the service **is** and continues to be.

Do not use two different tenses in the same sentence.

We saw people enjoying board games and they enjoy musical activity sessions. **X**

We saw people enjoying board games and a musical activity session. ✓

People enjoy a wide range of activities at the service. We saw people enjoying board games and a musical activity session. ✓

## 14. Use of quotes

If we use a direct quote in the report, this should be written in the language in which it was said; if the report is written in a different language to the quote you will need to explain the gist of what is being said for the reader, but you do not need to directly translate it. Write, for example;

“Rwy’n hapus iawn yn byw yma”, a person told us they are happy living at the service.

‘Rwy’n hoffi chwarae yn y twba tywod’. The children talked confidently to us about their favourite activities, such as playing in the sand tub.

Directly quote what people told us during inspection where this adds value to the report. Quotes should be written using *italics*.

A visiting health professional told us “*Care staff know people’s needs and likes.*”

A parent told us “*My child loves coming here, the staff are lovely.*”

A person using the service said, “*The staff are often very late.*”

It is important to note we do not use quotes that could identify the contributors although people’s views can be referred to in more general terms.

Do not use quotes from people receiving services where the service supports fewer than five people.

## 15. Numbers – quantities and proportions

It is important to be as clear as possible when writing about proportions. Avoid writing 'generally'. In inspection reports, please use terms that reflect the proportions shown below. Be clear if you mean 'nearly all' of the records you sampled, as opposed to all the records at the service. As a guide:

nearly all = with very few exceptions

most = 90% or more

many = 70% or more

a majority = over 60%

half = 50%

around half = close to 50%

a minority = below 40%

few = below 20%

very few = less than 10%.

## 16. Using evaluative or descriptive words to express ratings

Some words are more usually associated with particular judgements and evaluations than others are. The following suggestions of words and phrases can help you reflect the overall quality of care in each theme, and the ratings that have been awarded / would be awarded.

The use of any one word or phrase in the groupings below does not make any specific judgement inevitable, as this will depend on the balance and significance of any strengths and weaknesses overall, but they are a rough guide.

### Adult and Children's Inspection evaluative words

<b>Excellent</b>	With few exceptions, excellent, outstanding, very strong, exceptional, exemplary, superb, high, very high standard, very high quality, extensive, highly effective, highly creative, comprehensively, significantly, meticulously.
<b>Good</b>	Many people, successful, strong, safe, valuable, positive, thorough, useful, purposeful, used well, consistent, good, relevant, continuous, effective.
<b>Requires Improvement</b>	Not always, unsatisfactory, limited, inconsistent, falls short, unsuitable, unreliable, not robust, needs strengthening.
<b>Requires significant improvement</b>	Rarely, insufficient, hinders, inefficient, ineffective, unable, weak, poor, not fit for purpose, restricted, at risk, inadequate, significant shortfalls, lacking.

## Childcare and Play Inspection Evaluative Words

<b>Excellent</b>	outstanding, very strong, exceptional, superior, exemplary, superb, very high standard, very high quality, extensive, highly effective, highly creative, well above expectations, expertly done
<b>Good</b>	successful, strong, skilful, worthwhile, beneficial, valuable, positive, thorough, useful, powerful, purposeful, used well, consistently good, effective
<b>Adequate</b>	satisfactory, appropriate, suitable, competent, relevant, sufficient, enough, valid, solid, sound, limited, inconsistent, reasonable, acceptable.
<b>Poor</b>	: insufficient, inefficient, none, no, inappropriate, ineffective, unsuitable, unable, weak, poor, not fit for purpose, restricted

### 17. Inspecting following a concern

Where we undertake an inspection following a concern, do NOT say it was as a result of a concern. When planning the inspection, we should select the appropriate line of enquiry that will focus on the area of concern; we should consider the detail of the concern during the inspection, triangulating any evidence and reflect our findings in the report (positive or negative).

For example, someone has raised a concern with us about the environment being shabby and cold, so in the environment theme you would write:

#### **Example (Adult & Childrens Services):**

*Care and support is provided in an environment that is suitable for people's needs. People told us their rooms are always warm, furnished nicely and cleaned daily. The lounge and dining room are freshly decorated and the heating is set at a temperature people are happy with. Care staff told us the boiler had stopped working for two days, but the faulty parts were replaced very quickly and people were kept warm throughout.*

## Example Child Care & Play

*The environment is adequate for the children who attend. People who run the setting have begun to make improvements to the indoor environment, particularly the toddler room, where the layout is greatly improved. The person in charge agreed that further improvement to the dining room was required and there were plans in place to address this.*

## 18. Uninspected themes

The majority of inspections are full inspections considering all themes.

If, in exceptional circumstances, a theme has only been partly inspected, write at the top of the page of the relevant theme,

- 'We have not considered this theme, in full'

You will also need to comment in the summary that you have only inspected certain theme(s), for example, 'On this occasion we only considered the environment / care and support / care and development / in detail'.

We should always consider the theme of 'well-being'

## 19. Supporting Welsh language and culture

CIW has a leadership role in promoting Welsh language and culture in line with Welsh Government's More Than Just Words Action Plan. This is set out in CIW's [guidance for inspectors](#)

We include reference to promoting Welsh language in rating descriptors. In CC&P this is within Leadership and Management and in A&CS this is in well-being lines of enquiry.

CaSSI will populate the information table, at the beginning of the inspection report to reflect how well a service/setting is promoting Welsh language and culture .

Choose the statement that best reflects what you saw on inspection:

- The service provider anticipates, identifies, and meets the Welsh language and cultural needs of people.
- The service provider makes an effort to promote the use of the Welsh language and cultural, or is working towards a bi-lingual service.
- The service provider is not meeting the Welsh language and cultural needs of people and this requires improvement.

## 20. Short Observational Framework for Inspection (SOFI2)

You must use SOFI2 wherever possible (there are few exceptions). You do not need to reference this in the report. Simply write for example, 'we observed', 'we found' or 'we saw'.

## 21. How we report on areas requiring improvement

<https://www.careinspectorate.wales/securing-improvement-and-enforcement-policy.html>

In the main body of the report, under the relevant theme, summarise the issue (XXX below) and choose the most appropriate statement below to tell the public what action we are taking and why.

- *Outcomes for children/people **require improvement** because XXXX and we expect the provider to make improvements.*
- *Outcomes for children/people are **poor / require significant improvement** because XXXX and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.*

If we have previously issued a priority action notice but outcomes for people have not improved when we inspect again write

*This is still having an impact on outcomes for people and placing them at risk. Where providers fail to take priority action, we will take enforcement action.*

### Table outlining areas requiring improvement

See Part two for guidance on writing Outcome statements and Priority action notices

When you record areas for improvement or priority action in CaSSI, the information you record in the **Non Compliance Outcomes** section will be pulled through into the summary tables at the end of the inspection report;

The tables are intended to outline for members of the public why a service requires improvement or requires significant improvement / is poor and the date we identified this.

*Where we find outcomes for children/people **require improvement** but we have not found people to be at immediate or significant risk we highlight these as **Areas for Improvement** and discuss these with the provider. We expect the provider to take action and will follow this up at the next inspection.*

*Where we find outcomes for children / people are **poor / require significant improvement** and/or there is risk to children / people's well-being we identify areas for **Priority Action**. In these circumstances we issue a Priority Action Notice (s) to the Provider, and they must take immediate steps to make improvements. We will*

*inspect again within six months to check improvements have been made and outcomes for people have improved.*

*The tables below show the areas for improvement and those for priority action identified during our inspection, if any.*

Areas for Improvement	Date identified
Children have limited opportunities to play because the outside environment is not easy to access, and some resources are unsafe	30/01/2025

Areas for Priority Action	Date identified
People’s individual needs and preferences are not met because personal plans do not provide enough information to direct staff in the care they provide	30/01/25

## 22. National Minimum Standards (childcare and play only)

### Recommendations to meet with the National Minimum Standards

R1 The indoor premises should be maintained in a suitable state of repair and decoration.

R2 The outdoor play space should be well maintained.

National Minimum Standards are for childcare and play services only. If breaches in National Minimum Standards are numerous (over six) consider whether this amounts to non-compliance and a rating of poor for leadership and management. There will be times when a breach in a National Minimum Standards may also be linked to a breach in the regulations. Consider the Securing Improvement and Enforcement Policy for thresholds on issuing non-compliance.

## **23. Advice on issues with negligible impact or risk**

Sometimes issues are rectified either during the inspection itself or soon after the visit and before the inspection report is issued. These do not need to be recorded in the report but should be reflected in your planning and analysis document and recorded in CASSI.

## **24. Peer reviewers**

There is a separate peer review guidance and a peer review checklist.

## 25. Ten principles for clear writing; Source Sglein

Reference:- Robert Gunning, *The Technique of Clear Writing*

<p><b>Keep sentences short</b></p>	<p>Around 15 – 25 words should be sufficient for each sentence.</p>
<p><b>Prefer the simple to the complex</b></p>	<p>The temperature of the environment had fallen under the required 21 degrees. Use - we found the rooms were not warm enough for people.</p>
<p><b>Prefer the familiar word</b></p>	<p>Prior to – before Commence – begin or start Utilise – use</p>
<p><b>Avoid unnecessary words</b></p>	<p>Don't over use '<b>that</b>' or '<b>however</b>'. <b>Accordingly</b> - try 'so' instead <b>Constitute</b> - try using 'make up or 'form' instead</p>
<p><b>Put action in your verbs</b></p>	<p>Using the active voice tends to make writing tighter, more personal and introduces action earlier into sentences. Putting the 'doer' – the person or thing doing the action in the sentence – in front of its verb will usually ensure that the verb is active. The following sentence has an active verb.</p> <p><i>The Responsible Individual (RI) wants an improved service.</i></p> <p>The following sentence is in the passive voice as the 'doer' follows the verb.</p> <p><i>Two mistakes were admitted by the RI.</i></p> <p>To turn this sentence into the active, you simply bring the doer to the start of the sentence.</p> <p><i>The RI admitted two mistakes.</i></p> <p>Be careful of computerised grammar checker giving false passives. For example,</p>

	<i>The commissioners are concerned about the service.</i> In this example 'are' is active and 'concerned' is not a verb, but a description of the commissioners' state of mind.
<b>Write the way you talk</b>	<p>The young people very much enjoyed the event. Use - Children had a good time at the beach.</p> <p>Your writing will be closer to the way you talk if you favour the active over the passive, prefer the simple to the complex and favour the familiar word. It is helpful to read writing aloud to check it for jargon and sounding 'posh'. Be careful of overdoing this advice. Most of us don't speak in complete sentences. Good writing is speech organised and crafted.</p>
<b>Use terms your readers can picture</b>	Readers need context, not abstract. Explain clearly, what the situation is.
<b>Tie in with your readers experience</b>	<p>Our reports are written for the public. They need to be easily understood by people with little or no knowledge of the inspectorate or our methodologies. Consider the following sentence.</p> <p><i>The provision of adequate opportunity to explore their surroundings and interact with their peers should be a principle determinant of the curriculum of children under five years of age.</i></p> <p>This would be better written as follows.</p> <p><i>To ensure that young children grow and develop normally, one of the main things they need is to play with others.</i></p>
<b>Make full use of variety</b>	People living at the service, we found, we looked at records, people told us, staff told us.
<b>Write to express not to impress</b>	Reports must <b>inform</b> people about the quality of a service.

## PART TWO Writing Priority Action Notices and Outcome statements

### Thresholds (Impact/risk & likelihood of re-occurrence)

Remember a priority action notice is issued when **a provider needs to take action as a priority**. When deciding whether to issue a priority action notice, you **must** use the decision-making matrix in the securing improvement and enforcement policy. This provides detailed information on the thresholds for impact / risk and likelihood of reoccurrence. Remember:

- Refer to your inspection notes when deciding on the impact and level of risk.
- Consider the impact on outcomes for service users e.g. were service users unsafe, harmed.
- Evidence should be sufficiently triangulated to evidence impact and risk to service users.
- Refer to the history of the service when deciding the likelihood of re-occurrence. Has there been previous non-compliance? Was this addressed promptly and effectively?
- Are leaders committed and have capacity to manage / address the risk?
- Consider if there is evidence of on-going improvement at the service and if this is an isolated issue or part of a wider problem.
- Consider what (if any) measures are in place or likely to be put in place to address the failings?

### Choosing the right regulation

## 26. Root cause analysis

We issue priority action notices to get the provider to take prompt action to solve the issues we are seeing. We want the provider to work on the things that will make the difference. Therefore, it is important we identify the root cause of the failings we have found.

Carry out a root cause analysis to identify the issue(s): -

- Define the problem:
  - What do you see happening?
  - What have you read?
  - What have you been told?
- Gather evidence to establish the facts:
  - What proof do you have that the problem exists?
  - How long has it existed?
  - What is the impact of the problem?
- Possible causal factors
  - What are the circumstances/events that led to the problem?

- What conditions allowed the problem to occur?
- What contributory factors exist if any?
- Identify the root cause.
  - What is the reason for the problem? – evaluate your findings.

### **Example**

During an inspection of a service, you identify gaps in the staff training through your discussions with staff and reviewing training records. You speak with the manager:

Q: *“Why are there gaps in staff training?”*

A: *“Staff haven’t had time to attend so no training has been arranged”.*

Q: *“Why haven’t they had time?”*

A: *“They’re working double shifts / extra days to cover for those who are absent or have left. A number of staff have resigned so care staff are also covering for them”.*

Q: *“How long has this been going on for?”*

A: *“almost 3 months”*

Q: *“Why haven’t agency care staff been engaged, or new staff recruited?”*

A: *“I’ve raised it with the RI but she says there’s no need as we’re all doing a great job and the service can’t afford to pay anyone else. We’re all worried we won’t get paid this month”.*

This simple question-and-answer exercise leads to the root cause of the gaps in training which is that the financial viability of the service has not been properly managed.

## 27. Identify the specific regulation(s)

Ask yourself:

- What is the purpose of the regulation?
- Who is responsible for complying with the regulation?
- How does the regulation correlate with the root cause analysis?

### **A&CS Example**

During an inspection of a care home service under RISCA, we found personal plans had not been reviewed for 8 months and staff were unaware of people's preferred outcomes or their preferences.

Regulation 16(1) places a requirement on the service provider to review personal plans at least every 3 months. Regulation 80(1) and (2) place requirements on the RI to ensure suitable arrangements are in place to review and improve the quality of care and support and ensure those arrangements are reviewed at least every six months.

- If the root cause analysis finds personal plans have not been reviewed due to the RI's failure to put in place suitable arrangements to pick such matters, regulation 80(1) should be cited.
- If suitable arrangements were in place but no review had taken place, regulation 80(2) should be cited because the RI must carry out a review at least 6 monthly.
- If a review was carried out by the RI within 6 months but the personal plan had not been updated by the service provider, regulation 16(1) should be cited.

*Supporting evidence and an impact analysis should be tailored to each regulations cited.*

### **CC&P Example**

During an inspection, staff were unable to tell us what process they would follow if they had concerns about a child in their care. A member of staff told us they had concerns about a child which they had reported to the PiC but this had not been followed up and no records were available.

Regulation 22 places a requirement on the registered person to draw up and implement a written policy that sets out the correct procedures for the protection of children.

Regulation 29 3(a) places a requirement on the registered person to ensure that all employees have appropriate training, supervision and appraisal.

- If the issue was there was not a suitable safeguarding policy in place for staff to follow, Regulation 22 should be cited.

- If there was a suitable policy in place but staff had not received appropriate safeguarding training and had not had regular supervision and appraisal, leading to poor understanding of their role in relation to safeguarding practices, Regulation 29 (3)(a) should be cited.

*Supporting evidence and an impact analysis should be tailored to each regulation cited.*

### **Overarching regulation(s)**

Sometimes the evidence you have suggests more than one regulation has been breached i.e. a specific regulation and an overarching regulation e.g. Governance or RI oversight. Where this is the case, provide the detail of the evidence and impact in the specific regulation PAN and then summarise it in the overarching regulations. This is because you are most likely using the fact the specific regulations are not being met as evidence of lack of governance, oversight, or quality assurance.

## **Example**

Regulation 6 (RISCA) Regulation 9 (CC&P regs) (Service provide - Care Competence skill) PAN

### **Evidence:**

- The service provider has not ensured governance and quality assurance measures in place are sufficiently robust to inform improvement and development of the service and ensure people/children are appropriately safeguarded and protected.
- Learning and recommendations from incidents have not been put into practice resulting in people/children continuing to be put at risk of physical and emotional harm.
- The service does not have sufficient numbers of skilled and competent staff team accordance with regulation 34 (RISCA)/regulation 27 (CC&P regs). There continues to be a reliance on agency staff and staff from other services have been used to meet the staffing ratio.

## **Regulation Reg 27 CC&P - (staffing levels) PAN**

The registered person has failed to ensure that there are a sufficient number of suitably qualified, skilled and experienced persons looking after the relevant children.

### **Evidence**

- During the inspection on 15 May 2023 we found there were insufficient staff working directly with the children at key times throughout the day including morning breaks or lunch breaks.
- In the younger toddler's room, we observed 15 children being cared for by 2 members of staff for a period of 20 minutes as 2 staff members took a break. This does not meet the required staffing ratio of 1: 4 for this age of children. Staff failed to notice one child biting another child as they were busy changing children ready for outdoor play.
- We looked at staff registers for this room which showed several occasions during staff breaks when the required 1:4 adult to child ratio was not maintained. For example, on 21 April 2023 there were 18 children with 3 staff and on 29 April 2023 there were 13 children with 2 staff.
- CIW were notified on 10 May 2023, two children from the younger toddler room had left the premises and were found by a member of the public outside the nursery gates next to a busy road. The registered person explained the incident had happened during the staff break time and only 2 staff were caring for 16 children instead of the required 4. The 2 staff were busy setting up for lunch and did not notice the two children leave the playroom.

**Example Outcome statements:** 'Children are at risk of harm because there are not enough staff to care for them safely', or  
'Children are not safe nor receive appropriate levels of support because there are insufficient numbers of staff.'

### **Regulation Reg 34 RISCA - (staffing levels) PAN**

The service provider has failed to ensure that at all times a sufficient number of suitably qualified, trained, skilled, competent and experienced staff are deployed to work at the service.

#### **Evidence**

- During the inspection the manager told us staffing and recruitment is an ongoing issue at the service and there have been occasions where the service have been operating on very low numbers of staff. He explained the RI will not allow any agency staff to be employed to cover when staffing levels fall below the require level.
- We reviewed staff rota's for the last month and there were several occasions where staffing numbers were significantly lower than the services usual numbers. We saw the service were operating from 7pm on Saturday 15th June to 7pm on Sunday 16th June with only three staff on duty. At the time, there were 40 residents over three floors and four communal lounges. These are unsafe staffing levels for the complexity and numbers of people living at the service.
- During this time safeguarding referrals were raised by other professionals due to significant safety issues relating to lack of staff to meet the care needs of people. This included an increase of unwitnessed falls, poor recordings of people's nutritional intake and poor monitoring of changes in people's weight.
- During the inspection, inspectors saw two people who are at high risk of falls in one of the communal lounges calling out asking for help. On three occasions these individuals were attempting to stand, using nearby furniture to pull themselves up. There were no staff present at this time in this area. A relative and visiting professional went to these people and prevented them from falling.
- This exposed these people to further unwitnessed falls as there were no staff available to supervise and support individuals in the communal areas of the service. One of these individuals had already had two falls in the last two weeks resulting in significant bruising which was visible.
- We reviewed the dependency tools in place by the provider and found they weren't completed appropriately. People scored both high and low dependency on different tools and there was no consideration to the layout of the service and the amount of communal space.
- All care workers spoken too commented on how difficult the work was in the service and that the expectations of the management team were not

realistic.

Care staff explained that it was often lunch time before they had all the residents up, washed and dressed for the day due to staffing levels. They told us this had a knock on effect in them being able to ensure people had their meals and medication at appropriate times throughout the day.

- There has only been one occasion in three weeks that activities have taken place in the service as care workers haven't got time to sit with people and spend quality time with them.
- Staff feedback confirmed there is currently low staff morale in the service and care workers don't feel supported by the management team.

**Example outcome statements:** 'People are at risk of harm because there are not enough staff to care for them safely' or

'People don't get the support they should because there are not enough staff to provide it', or

'People do not receive appropriate care and support because there are insufficient staff to provide it'

## Presenting evidence

- **Evidence based:** When making statements and judgements, this must be backed up by evidence.

Avoid using standalone phrases such as '*safeguarding was poor*'.

This would be better phrased as '*Safeguarding processes are not robust as:*

- *When reviewing care records/incidents logs, we found person/child A had made an allegation to the manager of physical abuse against a member of staff.*
- *When we spoke to the manager, he confirmed this had not been reported to the local authority safeguarding team.*
- *The safeguarding policy we reviewed had not been updated since 2005.*
- *When we spoke to staff, they did not know the correct procedure to follow when they are told about or witness a safeguarding issue.*

- **Use of examples:** Focus on the best examples you have to support the statement you are making. Less is more; adding lots of lower-level evidence can sometimes make the PAN very lengthy, lack focus and detract from the point you are making.
- **Linked to regulations:** Ensure evidence directly links to the regulations (paying particular attention to the wording in the regulations).

Instead of saying “the service provider did not provide us with a training matrix” (this is not required under regulations), you could say:

- We saw no evidence of care staff receiving core training appropriate to the work they perform
- We reviewed five staff files and found no training certificates or evidence of manual handling training completed.
- Four care staff told us they have not received any formal training since starting their employment at the service and the manager was unable to provide any evidence of staff receiving supervision or training.
- We reviewed incidents records and saw two people had suffered bruising and injuries due to inappropriate use of manual handling equipment **or** when observing play in the outside play area the inspector saw staff were unable to manage children’s behaviour resulting in one child biting another child.

- **Opinions:** Avoid giving opinions that go beyond your role as an inspector.
- **Context:** Provide some context for the evidence in terms of proportion e.g. How many files were reviewed and how many were problematic.
- **Triangulation:** It is important to triangulate evidence where possible to include, what you saw (observation), what you read and what you were told (discussions with staff, people using the service, commissioners and any other stakeholders).
- **Re-issuing Pans** When a PAN is reissued following inspection, it will be cloned on CASSI, pulling through the initial evidence. This evidence should be removed and replaced with the new evidence. The previous evidence will still be available on the initial PANs and kept as an audit trail of decision making and evidence gathering. A short statement can be made at the beginning of the new evidence to outline it is an updated PAN. There is no need to keep in the old evidence.

*This Priority Action Notice was initially issued following an inspection on the 12 February 2023. During this inspection held on 12th June 2023, we found evidence to suggest the required improvements had not been made.*

- **GDPR:** Do not use names or initials of staff members or people using a service. You can use terms such as Person A or Staff Member A which helps to give a person-centred feel to a PANS. When recording in the planning and analysis document you can use full names. This ensures you can easily track

Person A back to the person being talked about in the planning and analysis document in case you are challenged further down the line.

- **Writing style:** Try to write following CIW writing style guidance [Writing Style Guide \(wales.gov.uk\)](https://www.wales.gov.uk/walesgov/writingstyleguide) which will provide some continuity across the report and PANS and remember these are formal documents and as such should not be written in note format or contain a lot of abbreviations.

## Outcomes for people

Outcomes for people should be clear throughout the evidence section and after every substantive point. This will enable the provider to understand the impact on people receiving the service... By embedding impact and risk throughout the PAN, we are focusing on the experience of people using the service.

The overall outcomes on people can then be summarised in a few sentences in the outcome statement section on CASSI. The outcome statement in CASSI should reflect the impact of the area requiring priority action (or area for improvement) on people (the what) and why it is happening.

e.g. People's well-being is not being promoted (impact) **because**.....

The outcome statements should reflect what you have found at that specific service (i.e. not generic).

Outcome statements should reflect the difference in level of impact between areas identified for improvement and those that lead us to issue priority action notices.

**Examples** are provided in the appendix.

**NB Outcome statements will be pulled through into the tables of Areas Identified for Improvement on the final page of the inspection report. They need to be written clearly to inform the public.**

**Example** Personal plans are not sufficiently informative to support people to achieve their outcomes.

- We reviewed four personal plans which were not person-centred, did not contain social histories, personal preferences, or people's personal goals.
- Reviews of personal plans did not evidence that people and their representatives had been involved. Person A told inspectors they preferred a bath to a shower. This was not evident in their personal plan and they were often told this could not be facilitated due to staff numbers.
- Person B spoke to inspectors about their interest in growing vegetables in the communal garden. This request was not recorded in plans or facilitated.

Person B told us this made them feel sad as gardening had always been something they enjoyed and helped to maintain their mobility.

- We spoke to two members of care staff who told us they have never looked at people's personal plans and rely on verbal handovers from nursing and care staff to understand people's health, care and support needs.
- The service relies on agency nursing staff and plans do not easily allow agency staff to understand people's care and support needs and to know them as individuals. People told us staff caring for them did not always understand their needs and preferences.

**Example outcome statements:** 'People are not receiving care and support in line with their assessed needs, personal outcomes and preferences because plans lack sufficient detail nor are they read by staff' or

'People's individual needs and preferences are not met because personal plans do not provide enough information to direct staff in the care they provide.'

### Recording in CaSSI

- It is important you complete all the mandatory fields in CaSSI. If you do not complete all the mandatory fields, the PAN will not show as ready to issue. Common errors are not completing:
  - o Direct evidence location
  - o Impact / risk / likelihood of reoccurrence
  - o Outcomes
  - o Manager decision and justification – once it has been reviewed and updated.
- Before sending the IN07 for review, check the internal review document. This will allow you to see how the information is presented in the document sent to the provider and is easier to read than the CaSSI record. You can easily pick up any formatting issues.
- Be clear about which parts of the CaSSI record pull through to the final document. You will be able to see this on the internal review document.
- Anything recorded in CaSSI should be written in full and not in note form.
- If you identify any errors at this stage, make the changes in CaSSI and generate a new internal review document via Smartflows.
- When the internal review document has been peer reviewed, you will need to make any amendments in CaSSI. Changes do not automatically update in CaSSI.
- You may find it useful to accept changes in the internal review document and copy and paste into the CaSSI record. This will save time.
- Managers should release the internal review document as the 'two ticks' version to ensure there is a record of the edit.

## Miscellaneous

- Check the PAN internal review document as you can see how it will be presented to the provider in the report. This makes it easier to pick up errors and formatting issues. It also enables you to sense check the narrative and how it flows. Once you have made the changes in the internal review document, you can easily copy and paste it into the evidence.
- Always ask yourself how you might be challenged on the evidence, the factual accuracy, weight of it etc? The purpose of this is not to prepare your arguments in defence. Rather it is to help you get perspective and objectivity.
- When you write the PAN, possibly take a break from it and then read it aloud or use the read aloud function in Microsoft Word. This can help you to be more objective in deciding if the evidence is logical and strong enough.

## Appendix: Additional Examples

### Adult example

#### Regulation 21: Standards of care and support - overarching requirements

During inspection we reviewed five personal plans and found discrepancies in the guidance provided to care staff and the observations of care provided for people. For example:

#### Person A

- Person A is 2-1 for any manual handling, including all transfers and continence care. Staff rotas covering the 19 November 2023 to 26 November 2023 evidenced at least four occasions where one person was on shift during the hours of 17:00 and 7:30am. This resulted in all of Person A's personal care and nighttime routine being completed by 17:00.
- Care staff told us Person A regularly asks if he can be put to bed later which is not possible due to only one member of staff on shift.
- Care records for Person A showed on at least three nights between 19 November 2023 and 10 February 2023, Person A was left in a soiled pad for at least four hours until a second person came on shift.
- Person A is isolated to their bedroom for long periods of time as they cannot mobilise around different areas of the home when only one staff member is present and they are put to bed too early, often against their wishes. This impacts on Person A's rights and entitlements over their day-to-day life and emotional wellbeing. There is a further risk to their health by being left in bed for extended periods of time and left in spoiled pads.

#### Person B

- Person B's care plan states they require pressure relief at least every four hours.
- Pressure relief records between 19 and 26 November 2023 showed on four of the nights, Person B went for seven hours without being moved.
- This has had a significant impact on Person B's physical health as they have had at least two serious pressure sores in the last three months which were deemed as being unavoidable.

#### Person C

- It is documented in their care plan that they are at risk of developing pressure sores. The intentional rounding charts states Person C has had a pressure ulcer in the past and requires strict two hourly positional changes and regular continence care from staff, however it does not specify what regular care is.
- We reviewed the intentional rounding charts for person C for November 2023 and found numerous examples when person C had not been repositioned every two hours. On eight occasions person C was not repositioned for more than five hours. On one occasion person C was not repositioned for over ten hours.

- On 3 February a nurse wrote ‘sacrum very red, had not been changed enough through the day. Person C states he is in pain because of this, please monitor.’

**Outcome statement:**

‘People are at significant risk of harm because they are not being cared for in a way that supports their health, safety and well-being’ or

‘People have come to harm and their health and wellbeing needs are not being met because the service is not providing the care and support they need.’

**Children’s services example**

**Regulation 36: Supporting and Developing Staff**

During the inspection we found the service provider does not ensure care staff are provided with the level of support and development required to carry out their job safely.

We reviewed staff files of five new care staff who started employment over the last six months prior to the inspection.

- There was no evidence of any of the new starters receiving an induction programme to ensure they were confident in their roles and practice. An induction process would have enabled staff to make a positive contribution to the well-being of individuals using the service.
- Furthermore, there was no evidence of any of the five care staff members receiving supervision during their time working at the service.
- Three new members of care staff told us they felt unsupported, had not had an induction and the manager was not providing them with the support they needed.

We looked at the training records for eight care staff who had worked for the service over six months.

- Only one had undertaken fire safety and restraint training and two had completed children with ligature training.
- The statement of purpose makes reference to the home being a “specialist home for children with high risk-taking behaviours” and there have been at least three incidences of self-harming behaviour and two occasions where children have caused a fire in the property.
- Training had not been provided to all care staff to meet the specific needs of children living in the home. Incident records referenced risk-taking and challenging behaviours by children, together with a high number of assaults on care staff.

- One child informed us they did not feel safe at the home as staff did not know how to respond when a child set fire to their bedroom and they did not feel confident that staff could keep them safe when displaying self-harming behaviours.

**Outcome statement:**

‘Children are at risk of harm because staff are not trained to meet their individual needs’ or

‘Children may be physically and emotional harmed because staff do not have the core training needed to meet the needs of children’ or

‘Children are not cared for appropriately because staff had not had sufficient training’ or

‘Children are at risk of emotional and physical harm as they are cared by staff who have not received core training.’

**CC&P Example**

**Regulation 29(3)(a)(b): Employment of Staff**

During the inspection we found the service provider does not ensure care staff are provided with the level of support and development required to carry out their job safely.

We reviewed staff files of five new care staff who started employment over the last six months prior to the inspection.

- There was no evidence of any of the new starters receiving an induction programme to ensure they were confident in their roles and practice. An induction process would have enabled staff to make a positive contribution to the well-being of individuals using the service.
- Furthermore, there was no evidence of any of the five care staff members receiving supervision during their time working at the service.
- We were told a staff member had been signed off to be safe to undertake nappy changing. We reviewed this staff member’s induction file and their induction record did not evidence this. A subsequent significant event occurred where a baby fell from the nappy changing station in the care of the new member of staff during the nappy changing.
- Three new members of care staff told us they felt unsupported, had not had an induction and the manager was not providing them with the support they needed.

We looked at training records for eight care staff who had worked for the service over six months.

- Only one had completed paediatric first aid training and only two had current safeguarding training.
- The statement of purpose specifies that all staff will have appropriate safeguarding and paediatric first aid training.
- Without staff receiving core training appropriate to the needs of the children being cared for, and in line with the statement of purpose, children are placed at risk of harm.
- One parent told us that their child had an injury at the service which required hospital treatment. The child did not receive appropriate first aid at the time of the accident which resulted in delayed treatment. The child's parents were not informed in a timely manner and there was no written record provided.

**Outcome statement:** 'Children are at risk of harm because staff are not adequately supported nor supervised' or

'Children have come to harm as the care staff are not provided with the training, support and supervision required to carry out their job safely' or

'Children are at risk because staff do not receive the support they need to follow safe working practices.'

## APPENDIX 1 REPORT EXEMPLARS

Exemplar Report – [Care Home](#)

Exemplar Report – [Care Home for Children](#)

Exemplar Report – [Domiciliary Support Service](#)

Exemplar Report – [Full Day Care](#)

## **APPENDIX 2 EXAMPLE OUTCOME STATEMENTS**

### **Example Outcome Statements**

#### **Environment**

People may not achieve positive outcomes because the building and grounds are not well maintained (AFI)

Children have limited opportunities to play because the outside environment is not easy to access, and some resources are unsafe (AFI)

People's outcomes are rarely met because they live in an environment that is poorly maintained and is a hazard to them (PAN)

#### **Care and support/development**

Children may not achieve positive outcomes because staff do not have a good understanding of their care and development needs (AFI)

Young people do not always receive good quality care or achieve positive outcomes because assessments are inconsistent and have limited information about their individual care needs. (PAN)

People do not receive appropriate care because the provider does not ensure their assessments are kept up to date and staff do not fully understand their needs.(PAN)

#### **Leadership and management**

People's well-being is at risk because of inadequate approaches to staff recruitment (AFI)

People are not safe because they are not cared for by staff who have been recruited via safe recruitment processes. (PAN)

People may be at risk because the provider does not follow recruitment procedures to ensure staff are suitable to work at the service. (AFI)

People are experiencing poor outcomes because the provider's selection and vetting processes at recruitment are inconsistently applied. (PAN)