

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

University Hospital

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

Care and welfare of people who use services	✓	Met this standard
Cooperating with other providers	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	University Hospitals Coventry and Warwickshire NHS Trust
Overview of the service	University Hospital provides a wide range of acute services for patients requiring planned and unplanned care including specialist services in cardiology, neurosurgery, stroke, IVF, diabetes, cancer care and kidney transplants. University Hospital is one of two hospital sites managed by University Hospitals Coventry and Warwickshire (UHCW) NHS Trust, serving a population of 1,000,000 people.
Type of services	Acute services with overnight beds Community healthcare service Urgent care services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Services in slimming clinics Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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Why we carried out this inspection

This inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 15 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and received feedback from people using comment cards. We were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During our inspection we visited a range of wards. These included the Accident and Emergency Department (A&E), the Medical Assessment Unit (MAU) (a unit which provides rapid assessment and treatment of a wide range of medical conditions – patients may then go home, or be referred to another medical ward), Ward 1 (Endocrine conditions), Ward 21 (general medicine) Ward 32 (ENT(Ear Nose and Throat)), Ward 33 (Urology), Wards 40 and 41 (Stroke and age related), and Ward 53 (Orthopaedics).

We looked at how dementia care was supported in wards where there may be a higher number of people admitted with dementia (for example Ward 40, Stroke and age related) and wards where there would be typically less people with dementia related needs, (for example, Ward 1, endocrine (diabetes, thyroid) conditions).

We spoke with 19 patients who had dementia or possible dementia and six relatives. We spoke with 29 staff that were on duty in all of the wards we visited and we spoke with the hospital's team of dementia specialists. We also looked at the treatment records of five patients with dementia or who were being assessed for dementia.

We left comment cards and boxes for people to post their comments on each ward we

visited. After a week we collected the cards. We received 25 CQC comments cards, and five of the hospital's comment cards. All people who wrote comments were positive about the care provided by staff but there were some concerns expressed about staffing levels.

We saw patients with dementia were placed on the hospital's 'Forget me not' dementia care pathway. This meant on admission and throughout their time at the hospital, staff would know they had dementia and provide the appropriate support.

We saw there were good systems in place to assess and support people who had no formal diagnosis of dementia, but who were confused or who had difficulty with communication.

We saw patients were kept safe because their risks were appropriately and sensitively managed. For example, the hospital used pictorial images on the patient board or above the patient's bed to alert staff whether the patient had dementia or was at risk of falls.

We saw staff worked well with other departments in the hospital to ensure all medical, social and psychological needs were met. We saw staff worked closely with other services to ensure specialist assessments were completed and people were discharged from hospital safely.

All staff we spoke with understood the importance of meeting the needs of people with dementia. We saw staff were committed to making the hospital a dementia friendly place.

We observed staff supporting patients with dementia. We saw staff worked with patients in a caring and compassionate way.

Patients and their relatives told us,

"X's care has been first class. My family and I have felt quality of care is very good. He has been treated with compassion, respect and dignity."

"We have seen very good care in this hospital and patients are looked after, treated well and it has a good environment."

Services for people with dementia were well led. We saw the hospital board was fully supporting the specialist dementia team to respond to and improve the services they offer to people with dementia.

You can see our judgements on the front page of this report.

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

How are the needs of people with dementia assessed?

We saw patient's needs were assessed when they were admitted to the hospital. This was done through staff talking with the patient and/or their relative to get information about the patient's current and previous medical conditions, mobility, mental health, personal care and safety needs. Risks to patient's nutrition and mobility were also assessed and planned for. During this initial assessment, people with a known diagnosis of dementia were identified and placed on the hospital's dementia care pathway.

For patients who had been assessed as showing signs of confusion, we saw the specialist dementia team of staff were asked to assess whether the patient had dementia. A support worker told us, "If a patient is confused we refer them to the dementia team. They do not always have dementia; they might be suffering from trauma, constipation or a UTI (urinary tract infection)."

We were informed the hospital tried to screen all patients admitted who were over the age of 75 to determine whether they had any memory loss. Where concerns were identified, the patient would either be referred to the memory clinic or a letter would be sent to the GP to inform them of the results and for further investigation at a later date. We were told the hospital had screened 90% of patients who had been admitted to the hospital for 72 hours or more.

How is the care of people with dementia planned?

The hospital used a dementia care pathway called the 'Forget me not' bundle. This meant staff completed a form called 'Getting to Know Me' at the beginning of the patient's hospital stay. The form provided staff with information such as the patient's likes and dislikes, their preferred name, their daily and nightly routines, dietary and walking needs.

On all wards we visited, we saw this form had been completed where possible. We saw the form had not been completed when the patient was too confused to help staff complete the form, and where there was no family or carer support. For example, we saw one

person had no family or friend involvement and was too confused to understand questions directed to them. We also saw two patients had been admitted from care homes to A&E without a care worker with them to support their admission and with minimal written information provided. Nursing staff told us they would be able to get the information from the care home, but it would have been helpful to have had the information on admission to understand what made the patient anxious or agitated.

We were told patients on the 'Forget me not' pathway would have the Forget me not flower by their name on the ward 'patient board' or above their bed. This informed staff quickly that the patient had some form of confusion or dementia and helped staff respond appropriately. For the majority of patients we looked at, we saw the flower was where it should be. The dementia team told us they were in the process of improving this initiative by introducing blue coloured pillow cases for patients to use who were on the pathway.

We were told the blue pillow case would go with patients wherever they were in the hospital, and would improve quick identification of patients on the dementia pathway. We asked whether departments knew in advance of a patient with dementia being referred to them, for example if a patient was referred for an X-ray. We were told they did not. The provider might like to note the importance of having a system where departments are informed in advance so staff can plan to cater for the patient's needs. For example a patient with dementia may need a longer appointment.

We saw Ward 40, the Forget me not ward, had been designed specifically to support people with dementia. The corridor wall outside the ward had a 'memory lane' for all people to enjoy. The ward had a communal lounge with comfortable sofas and a dining room table. It also had equipment to encourage patients to relax and reminisce, and an activities room. A comment from one of our comment cards said, "Generally very good care for dementia patients. Exceptional on Ward 40 and if other wards were as well supported whole hospital would be excellent resource in dementia."

We spoke with two patients on Ward 40, they told us they loved the activities available and having company. One patient aged 95 told us on the previous day to our inspection they had played bingo for the first time in their life.

We were told by the dementia care lead they planned for the hospital to be 'dementia friendly' on all wards. This was because they could not accommodate all patients with dementia in specialist wards, and they felt staff in all areas of the hospital should be able to support people with dementia or confusion.

We saw on each ward there were nurses who had been identified as 'dementia link nurses'. They had undertaken dementia training and liaised with the dementia team in ensuring those with dementia were fully supported. Staff we spoke with on all wards knew who their dementia link nurses were.

Are people with dementia Involved in making decisions about their care?

We saw in care records the patient's capacity to make decisions about their care had been assessed by the appropriate health and social care professionals in accordance with the Mental Capacity Act. Those who did not have capacity to make significant decisions about their care had decisions taken in their best interests by health and social care professionals, advocates, and family members. We saw notes which demonstrated the full involvement with families over key decisions.

We saw some patients had made decisions not to be resuscitated, and these decision were in their care records.

We saw staff support patients to be fully involved where possible in day to day decisions about their care. For example, we saw one of the patients was not happy with the food they had received. We saw a member of staff explain they could have a different choice but it would take another 20 minutes (the patient had been saying how hungry they were). The patient decided to wait the extra time for a meal they preferred to eat.

Are people with dementia provided with information about their care?

We saw staff gave patients information in a way that reflected their abilities to understand and absorb what was happening to them. For example we observed a staff nurse take their time to explain the treatment being given to a patient and how it would aid their recovery.

Patients told us,

"The staff are very good to me and they speak to you and tell you about your treatment."

"The staff explain to me about discharge planning and I am made well aware of what is going to happen."

"I had a catheter removed and I was informed at every stage."

A visiting relative told us, "They keep my mum informed when any changes are going to happen."

One patient was less positive. They told us they were not informed about their care. They told us they were having blood tests on the day of our visit and they did not know why.

In two of the patient records we looked at, the section which checked whether staff had orientated patients to the ward was not completed. This meant we did not know whether the patient had been informed of their consultant's name or shown how to use the call bell.

We saw each ward had a ward information leaflet. For example, the leaflet for Ward 41 gave information about the consultants and senior nursing staff involved in patient care, visiting times, discharge arrangements, mealtimes, Age UK, complaints, and useful contact numbers.

How is care delivered to people with dementia?

We spent time speaking with staff and patients in A&E and the MAU. Staff acknowledged to us that A&E could be a difficult place to care for people with dementia because the environment and patient flow could cause problems. They told us they tried to prioritise getting people with dementia onto the wards if they were being admitted but said this could still take several hours. We were told the Trust had recognised this and was working to improve provision for the frail elderly and people with dementia. We were told in both A&E and the MAU, patients with dementia were placed close to nursing stations where they were more visible.

We were informed that patients in A&E had access to food and drink, but it was a limited choice of refreshments.

We received five comments from A&E, they were not on our comment cards, but on A&E comment cards. All respondents were very positive about the treatment and care they had received.

We saw patients being supported by staff who on all wards were observed as kind and

considerate to patients' needs. For example, on Ward 41 we observed nursing staff support a person whose behaviour was challenging to them and to other patients in the ward. The patient had only recently been admitted to the ward and was anxious and agitated. We saw staff listened and responded to them. When we came back to the ward later in the day the patient was calm and happy. They were able to speak to us and recognised their behaviour had been different earlier in the day. They had in a small space of time built a good rapport with the nursing staff supporting them.

We were told by staff they tried to ensure there was a mix of male and female staff to meet the preferences of patients with regard to personal care. We were informed on Ward 1 they had recently admitted a patient who was Polish and had difficulty in communicating with staff. The hospital provided an interpreter to help staff understand their needs. This meant the hospital was working to support the diverse community it served.

We saw by looking at patient records and by talking with staff that patients presenting with confusion were assessed to determine whether the confusion was a result of dementia or another medical condition. For example, checks were made to rule out whether confusion or delirium was a result of an infection. If the infection was treated and the delirium remained, we noted that patients were then referred to mental health teams for assessment.

We were told by staff the hospital's visiting time during week days was in the evening, but where there was a need, and in the best interest of the patient, the visiting hours would be extended. A nurse told us, "We encourage families to come in and assist. Families mostly come in the evening." We saw one patient's relative visited at lunchtime because the patient needed assistance with eating. We also saw volunteers were used to support people with eating. We spoke with a volunteer on Ward 41. They told us they had been volunteering at the hospital for a long time, and they always supported the same patients to eat. This provided the patients with continuity of care.

We talked with staff about the management of patients with behaviour which challenged staff and other patients, or who had risks in relation to falls. They showed us the 'safe level of observation assessment' form they completed if they felt they required additional staff to support identified patients. We were told by staff they felt the hospital had improved in its responses to these requests, and usually staff were supported when needs were identified. A staff nurse in MAU told us they had observed support workers taking it in turns to sit with a patient the previous day as the patient was agitated, but the "patient was much better today." A member of staff on Ward 33 told us they looked at providing activities for people to help manage anxiety. They gave an example of a recent patient who was really interested in trains and so they provided train magazines which the patient spent time looking at.

We saw some wards had activity co-ordinators to support people to engage in meaningful activities. On Ward 40, the main ward supporting people with dementia, we saw two activity co-ordinators had been employed. This meant there was an additional 12 hours of support for people with dementia on the ward each day. We were informed on Ward 1, a health care assistant was liaising with a charity to use some funds to turn a room into a lounge where activities for patients with dementia could take place.

We were told some nursing staff had undertaken training in a foot and hand structured touch technique which was designed to reduce agitation and help patients to relax. This meant the hospital was looking at non drug therapy to support patients to be calm.

We saw the hospital used the 'Abbey Pain Scale' to assess patients with dementia who were unable to verbalise. This is an assessment tool which looks at changes in behaviour, body language, facial expression, and physical changes to determine whether a patient is in pain. This meant the hospital was proactive in identifying and reducing pain in patients with dementia.

We also saw wards had practical ways to reduce risks. For example, patients who were at high risk of falls were admitted to an area of the ward where there was always one member of staff. There were also visual cues above patients' beds to inform staff of particular needs, for example being at risk of falls, or if they were being supported by the speech and language team (SALT).

We saw the hospital had systems in place which ensured appropriate assessments were completed in a timely way. We were shown tracking information that ward managers and matrons used to ensure patients on their ward were having the care and treatment required so they were not in hospital longer than was necessary.

We asked patients during our inspection what they thought of the care they had received. Patients told us:

"I am absolutely well looked after, like a diamond."

"The staff are very good to me; they speak to you and tell you about your treatment...one male staff nurse is excellent."

"Extremely courteous staff, tremendous nursing care and it is not regimental...the food is nourishing...and there is a choice of food. It is like the Ritz here...the beds are changed, cleaning is absolutely wonderful and I would be proud to be working here."

One patient was not happy with night time care. They told us, "I had two accidents at night in the last two weeks...I called staff and for five minutes no one came."

Comments received from our comment cards included:

"My friend's Grandmother was a patient on this ward (33) and the family were all very happy with the care. She was a pleasant but very confused patient who required lots of reassurance. The nurses were brilliant with her."

"In my experience, I have witnessed staff treating elderly demented patients with real care and compassion. They are real angels."

We received seven comments from people who worked at the hospital. They generally thought dementia care was good but felt there was a need for more staff. Comments included:

"The staff on the wards treat patients with dementia with compassion, respect and dignity. However, often there are not enough nursing staff on the ward and this lack of staff compromises the care that the nurses can give. There is also a lack of resources - a day room, communal dining table, music, tea parties, activities coordinator etc. would help. There are also never enough staff to feed the patients at meal times."

"Poor. Insufficient staff to deal with the complex needs of patients with dementia. Visiting times are out of working hours making communication with relatives or gaining

collaborative history difficult."

"I feel that the care given to dementia patients is very much determined by staffing levels, if the ward is short staffed the nurses can only do so much and are unable to ensure good quality care and definitely unable to provide a safe environment. Volunteers helping at mealtimes help the staff provide good, quality care."

Although staff told us they needed more staff to ensure patients' safety, patients and relatives recognised that staff were compassionate and did their very best for patients with dementia.

Is the privacy and dignity of people with dementia respected?

We observed staff supporting people's privacy and dignity. For example, we saw curtains were fully pulled around the patient's bed when staff were undertaking aspects of personal care.

Staff told us how they would ensure people's privacy was respected when undertaking personal care. For example, they would make sure when washing a patient, they covered the parts of the body not being washed.

We saw pictorial symbols were placed above patient's beds or on the ward board as an aid memoire to staff about particular needs. This protected the patient's privacy and dignity because visitors to the ward could see the symbol, but did not need to know what it meant.

We observed people with dementia being supported to eat their lunch. Three inspectors undertook observations in three different wards of the hospital. We saw staff check that patients were happy with their choice of food. We saw staff who were supporting patients to eat ensured the patient was not hurried. We saw good communication throughout. We saw on one ward, two of the staff were standing up whilst they helped a person to eat. The provider might like to note the importance of staff sitting at the same level of people when providing this support.

We spoke with patients about privacy and dignity. They told us:

"My privacy and dignity is maintained to the maximum...I am still not called by my preferred name and all staff address me by my christian name (which they did not like)."

"The nurses and assistants are sensitive (with personal care)."

Comments from our comment cards included, "My family and I have felt quality of care is very good. He has been treated with compassion respect and dignity."

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

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

Does the provider work with others when providing care to people with dementia?
We spoke with the GP liaison nurse. We were told they were the key person who GPs' spoke with when they wanted to send a patient for admission. We saw the GP liaison nurse worked to ensure all services, such as community based services were accessed.

We spoke with staff on the A&E unit about admission and discharge procedures for people with dementia. Staff told us of some of the challenges they faced if a person with dementia came without care workers or relatives to help staff understand their needs. For example, staff faced challenges if they did not know what made patients agitated or frightened. We were also told that not all care homes provided written information to support nursing staff in understanding the needs of newly admitted people with dementia. We were given an example of a patient who came from a care home the night before our visit. Staff told us they had received basic personal information, but nothing which would help them know what would trigger agitation or distress or any calming strategies which worked.

As part of the national dementia themed study we asked some local care homes of their experiences of people being admitted to, and discharged from the hospital. Managers of care homes told us that sometimes the information they provided the ambulance staff to give to nursing staff on admission appeared to get lost. They told us that nursing staff contacted them requesting information they should already have received. They also told us sometimes the discharge information sent back with the person was insufficient to help them understand how the needs of the person had changed. The provider might like to note the importance of ensuring the written information sent to the hospital is kept safe, and the discharge notes fully inform people delivering care of any changes to care needs.

We looked at the discharge experience of patients. We saw patients who were on the wards were able to wait by their bed in a familiar environment whilst waiting for transport. Those in A&E were moved to the hospitality lounge to wait. We were told when patients relied on ambulance services to transport them back to their homes, they could wait sometimes more than four hours. On the day of our visit a patient with dementia had been admitted to A&E at 3.30am and had been moved to the hospitality lounge at 8.25am, they were still there at 12.45pm waiting for discharge. Nursing staff tried to support people with

dementia by providing them with a bed in the hospitality lounge if possible. Staff were clear it was not ideal to have people with dementia waiting this long or in this environment.

We saw the discharge of patients in the Hospitality Lounge was not delayed by waits for medication on week days. This was because a specific outreach service from the main pharmacy operated on the same corridor on week days. This service was not available at weekends. The provider might like to note the value of having this service available seven days a week.

We saw from the moment a person was admitted to the ward, a discharge team looked at what the patient's care needs might be on discharge to ensure no one was discharged unsafely. The team also identified the risks of delayed discharge. A nurse told us, "Some patients can be safe at home with a package of care; other patients might have more complex needs that need referring to a social worker. The internal discharge team (IDT) deal with it" and "They are very very good." For example, we saw one person was unable to go back to their home because they had been assessed as unsafe to live on their own. We saw hospital staff had worked hard with other agencies to try to secure a safe place for the person to be discharged to.

Staff told us the ward clerks were often over stretched because they had a lot of patient records to update and phone calls to make, as well as having a role in receiving patients and visitors to the ward. The provider might wish to consider improving the numbers of ward clerks to ensure records are updated in a timely way to reduce delays in moving patients through to discharge.

We were told the hospital worked well with the community mental health team and psychiatry services. However, there were a number of staff who told us they were not happy with access to psychiatry notes. Staff told us psychiatry notes were kept on a different computer system and most of the time they got information about the patient from the psychiatrist's medical secretaries. This meant they could only get access to the information between the hours of 9am and 3pm during the week. We were told of an occasion where the lack of access to psychiatry notes had led to nursing staff making a wrong assessment about the care pathway of a person. It had not put the person at risk, but had unnecessarily wasted staff time.

We were also informed psychiatry records held information about specific medicines prescribed by the psychiatrist such as cognitive enhancing medicines (drugs used to treat conditions such as Alzheimer's). Without access to psychiatry notes, we were told staff would not be aware of this and could impact on the care and treatment provided.

A clinician told us the social work department 'demand' a diagnosis of dementia is made by psychiatry. They told us this delayed patients move to discharge and was unnecessary because geriatricians (a doctor who specialises in the care of people aged 65 or over) were skilled to make this diagnosis. The provider might find it useful to note the importance of clinical and nursing staff having ready access to all records which are required to assess and plan patient treatment.

Are people with dementia able to obtain appropriate health and social care support? By looking at patient notes, talking with patients and staff, we saw that patients were referred to appropriate health and social care professionals both within and external to the hospital environment. For example, we saw one patient had been referred to speech and language therapy because of concerns about poor nutrition. Another patient who was unable to bear their own weight was referred to the physiotherapist. Their care plan

included regular sessions with the physiotherapist to build up their muscle strength.

Patients had also been referred to care facilities for continuing healthcare support on leaving hospital, and to other agencies that could provide support with specific needs. For example, one patient's notes showed they had been referred to the community alcohol team because they had been identified as having a history of excessive alcohol consumption.

We spoke with staff on Ward 41. They told us the hospital received support from Age UK in helping patients without the support of family or friends to be discharged safely. We were told Age UK helped to transport patients home and ensured they were safe and settled at home before they left. We were also told Age UK helped organise care packages for patients ready for their discharge from hospital.

Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

How is the quality of dementia care monitored?

We saw the trust was involved with the National Audit of Dementia. This is an audit funded by the Healthcare Quality Improvement Partnership (HQIP) and managed by the Royal College of Psychiatrists. The standards for the audit were based on the National Institute for Health and Care Excellence (NICE), the Department of Health guidelines, professional guidelines, and recommendations by organisations representing service users and carers, for example the Alzheimer's Society and Age UK.

We looked at reports to see how the trust was working towards the recommendations from the audit. We saw for example, the trust was working towards a dementia friendly discharge policy. The trust's board was also going to be made aware of incidents of discharge taking place after midnight or when carers or family members receive less than 24 hours' notice. This was to ensure people were discharged safely.

We saw the hospital had risk management computer software which monitored incidents, adverse events and near miss reporting. Staff told us they would put information on the system when an event occurred and the system would track what had been done, when, and any resolution. We were told the system monitored trends and patterns. A nurse told us, "The matron holds meetings and tells us the actions that need to be taken...information sharing is mostly effective."

Staff told us that Nursing Quality meetings were held monthly. In these meetings ward managers looked at the data provided by the computer software and looked at how they could improve their service.

We asked staff whether the trust's senior management monitored dementia care by coming to the wards and spending time on the wards talking to staff, relatives and patients. We were told senior management 'walked' the hospital but staff did not see them spend time in the wards observing and interacting with patients and staff. Staff told us they wanted senior management to be 'on the shop floor' to see what work they did well, and to see for themselves some of the challenges staff faced in providing a quality service.

We asked to see whether the trust had received any complaints relating to dementia care in the last year. The trust provided us with a break-down of complaints related to dementia care. We saw out of the approximately 500 complaints received by the trust for 2013, eight complaints referenced 'dementia'. We saw the trust had taken appropriate action in investigating each complaint and had followed up each one with action. For example, one complaint was about discharge arrangements being changed at short notice, a lack of communication with the family, and inappropriate transport arrangements. The trust acknowledged this and apologised. They also ensured staff understood the policy on booking transport for patients with dementia.

How are the risks and benefits to people with dementia receiving care managed?

At ward level we saw systems were in place to increase staffing when required, to reduce the risk of falls, medicine errors, and to ensure people were referred to other departments and services in a timely way.

We saw by looking at patient records that patients planned discharges were cancelled if the patient's condition or circumstances changed. This meant the trust was keeping patients safe.

We saw the Forget me not care bundle asked staff to check that patients with dementia had sufficient support with eating and drinking, their environment was safe, and, as much as is possible in a ward environment, the ward was not noisy because noise could lead to agitation.

We saw each ward had a dementia 'link' nurse who had attended specific training in dementia to support patients on the ward with dementia, and to help other staff understand how to support patients. We also saw the dementia team was widely used by ward staff when a person without a formal diagnosis of dementia was presenting with confusion and signs of dementia.

Nursing staff we spoke with told us they found the dementia training valuable in helping them understand the needs of people with dementia. We were told dementia training had been mandatory for all staff but was no longer provided to non-clinical staff. This meant other staff such as porters, receptionists and domestic staff who would be in day to day contact with people who have dementia were not receiving information that may help them undertake their work effectively with patients who had dementia. The provider might like to note a dementia friendly hospital would benefit from having all staff trained to have a basic understanding in dementia care and communication.

We were informed the Chief Operating Officer of the hospital had agreed to be a 'dementia friend' and was going to receive training to support them in this role.

Are the views of people with dementia taken into account?

We saw staff listened and respected the views and opinions of patients with dementia in terms of daily routines and choices.

We saw where patients had been assessed as not having the mental capacity to make their own decisions, family and advocates had been involved with decisions which were taken in the best interest of the patient.

We saw an 'Impressions Survey' was conducted by the trust. This is a questionnaire given to patients, their carers, friends and family to complete. We could not determine how many people who completed the questionnaire were patients with dementia or visiting patients

with dementia, however we were given a breakdown of results of people between 76-85 years and 85 years plus from 2 April 2013 to 15 January 2014.

For people over 85 years of age, the trust scored 98% in people saying staff treated them with kindness and compassion, and feeling safe in their care. The trust scored 96% of patients saying their privacy and dignity was respected. For people in the 76-85 year age group, the scores were 96%, 95% and 96% respectively. For both age groups the results were lower at 86% in relation to 'the way we discharged you.' We noted the board was working on discharge arrangements to improve people's experience of this.

About CQC inspections

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

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

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

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

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

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

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

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

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

You can tell us about your experience of this provider on our website.

How we define our judgements

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

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

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

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

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

How we define our judgements (continued)

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

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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