## Worcestershire Acute Hospitals NHS Trust
### Alexandra Hospital

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<th>Region:</th>
<th>West Midlands</th>
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<td>Type of service:</td>
<td>Acute services</td>
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<td>Publication date:</td>
<td>May 2011</td>
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<td>Overview of the service:</td>
<td>Worcestershire Acute Hospitals NHS Trust is an acute trust which provides a wide range of services which includes emergency care medicine, surgery, maternity services and pediatrics. Services are provided to a population of around 550,000 people in Worcestershire as well as caring for patients from surrounding counties.</td>
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Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that the Alexandra Hospital was not meeting either of the essential standards we reviewed. Improvements were needed.

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

Why we carried out this review

This review is part of a targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met.

How we carried out this review

The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

We reviewed all the information we hold about this provider, carried out a visit on 22 March 2011, observed how people were being cared for on wards five and 11, talked with five people who use services and one visitor, talked with eight members of staff, checked the provider’s records, and looked at records of people who use services.

What people told us

During our observations on both wards we spoke with a total of five patients and one visitor. People we spoke to were generally complimentary of the care they had received from staff in the hospital. However, some people told us that they were not given any information on their arrival to hospital and that they were not always kept informed of what was happening to them. When we spoke to people about how staff respond to their individual needs some people told us that they often experienced delays in getting help from staff when they pressed their call bell for help.

People we spoke to were very complimentary of the meals provided to them and most people were able to choose what they wanted to eat from a menu. However, none of the people we spoke to said that snacks were available to them between meals.
What we found about the standards we reviewed and how well the Alexandra Hospital was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

- Overall, we found that improvements were needed for this essential standard.

Outcome 5: Food and drink should meet people’s individual dietary needs

- Overall, we found that improvements were needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 1: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns
with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

During our observations on both wards we spoke directly with five patients and one visitor. People we spoke to were generally complimentary about the care they had received from staff in the hospital. One of the people we spoke to said that they had never felt uncomfortable or embarrassed during their stay and that they were very happy with all aspects of the care. Another person said how they felt embarrassed using a bed pan but staff had been very reassuring. One person in a side room spoke about the benefits of having a room to themselves.

However, when we spoke to people about how staff respond to their individual needs, some people told us that when they pressed their call bell they often experienced delays in getting help from staff. One person said they sometimes have to ring the bell to get help for other people as their bells may not be within their reach.

When we asked people if staff called them by their preferred name one person said
‘No not really, they call me by my first name’. Another person said staff did not ask their preferred name and used different names at times.

We asked people about the information they received when they came into hospital. Most of the people we spoke to said that they were not given any information when they arrived at the hospital. One person who had been a patient for four weeks told us that everything had been fully explained to them and that staff had been marvellous. They were happy with the care given. They said they were very scared when they came in and staff put their mind at rest.

One patient told us that they had been given a book ‘your stay in hospital’. The book contained information about what to expect when in hospital and what facilities there were. The book did not appear to be widely available on the ward.

People were also asked about the treatment they had received and if staff explained their treatment to them. Two people we spoke to said that nothing had been explained to them about their condition and that sometimes they are not told that they are going to have a blood test and they only find out when staff come to take their blood.

There were a number of occasions where we heard positive interaction between hospital staff and patients. Physiotherapists and occupational therapists took time to introduce themselves directly to patients, explain what they planned to do and gained consent before providing treatment. We heard one consultant carrying out a ward round. They introduced themselves to the patients, and in a calming voice checked how the patients were feeling, checked their level of understanding about their treatment and took time to explain what was not understood.

Other evidence
The trust’s website has a section devoted to privacy and dignity outlining the trust’s commitment to patients. The page refers to both equality and diversity information and has a copy of the privacy and dignity policy (dated 1 November 2010). The policy applies to all trust employees and makes it clear that lead clinicians, matrons, ward and departmental managers are responsible for ensuring compliance with policy.

During our observations we saw and heard numerous examples of staff caring for patients in a way that respected their privacy and dignity, with bedside curtains being drawn when personal care was being delivered or private conversations being held, and staff talking to people in a warm and appropriate manner. We saw some examples of patients making choices about day to day activities. People were being asked if they wanted to rest in bed or sit out in a chair and choosing whether to eat their meals or take fluids.

Staff were able to tell us how they ensure the privacy and dignity needs of people are met referring to the use of privacy curtains, having protected mealtimes and restricted visiting. They said that family or carer involvement at mealtimes is permitted with the individual patient’s permission and is monitored to ensure it is
proven to be beneficial. Wooden lockers were situated by each bedside for patients to store their belongings. However, these were not lockable.

In contrast, we saw some examples where this was not the case. There were four occasions where staff talked to patients in a disinterested manner rather than engaging in conversation and where staff talked in a loud and condescending manner towards some patients. Other observations included staff removing medication charts from the end of patients’ beds, which they did without engaging in conversation or discussion with the patients concerned. We saw one nurse giving people medication and nutritional drinks. Interaction was limited and task focused with no explanation to the patient.

On several occasions we overheard conversations being held in open areas of the ward and personal information about patients was being discussed. When we spoke to one member of staff they said that any sensitive issues should be discussed at the nurse’s station but that this was not always the case. We did not see this happen during our visit. We observed a staff handover on one ward. The handover comprised of discussion and information about patients, and took place outside of bay areas and side rooms. The discussion could easily be overheard by people within the main ward / reception area and where doors to bays or side rooms were open.

Staff told us that they had received some training on the Mental Capacity Act 2005 and how it applies to their roles. They said that they involve relatives and social workers if someone lacks capacity or is frail. They referred to a lifestyles and capabilities booklet ‘About me’ and a ‘My Hospital Book’ which are used to gather information to ensure the needs of people who may have a learning disability are met. We were told by staff we spoke to that advocacy services were not widely used.

Staff also told us that they try as much as possible to meet the diverse needs of patients and to support people whose first language may not be English. The Trust had systems in place for staff to access qualified interpreters for patients for both face to face and telephone interpreting. Staff told us that they also work closely with family members or carers where possible to ensure people’s individual needs can be met. There were also arrangements for the provision of British sign language interpreters for deaf and hard of hearing patients.

We asked staff if they had received training and guidance on privacy and dignity. Those we spoke to were relatively new to the trust. They had been given training at their induction but they had received no specific training since then. A member of senior staff told us that many staff were behind with their training. One member of staff said that they felt on the whole dignity was respected but this was not always the case.

We looked at a selection of medical records and care plans. Care plans contained no information about the specific preferences of patients. With the exception of records by physiotherapists and occupational therapists, records seen showed no
details of the information that had been given to patients and we did not see any systems for providing information to patients/relatives. None of the records seen during the visit showed evidence of mental capacity assessments being carried out.

Not all call bells were readily accessible to patients and in one instance we saw another patient call for assistance on behalf of someone else who had no bell available to them. We saw people asking for assistance and having to wait some time for help, this included people with high dependency needs. We saw that when people had used bedpans at the bedside they were not offered wipes or hand washing.

When we spoke to one member of staff about how they managed to meet the needs of people on the ward, they said that they did not have enough time to care for patients. They said that when they are rushed they cannot always meet people’s needs and some things have to be delayed as a result.

We asked staff how they get feedback from people who use the service. We were told that there used to be feedback forms but these were no longer available. Staff said they receive feedback in a number of ways which includes direct feedback, via letters and ‘thank you’ cards and where necessary by complaints procedures.

The trust has a complaints procedure and we saw ‘complaints, comments and compliment’ leaflets on display in each ward. In addition to this Patient Advice and Liaison service leaflets were also on display.

There is a patient experience committee chaired by the chief executive whose work includes the review of dignity in care throughout the trust. An analysis of all complaints received is carried out and twice yearly reports are made to the patient experience committee who look at the complaints and review actions taken. Sample copies of these reports were made available to us following the site visit.

Monthly quality reviews are carried out by the divisional /hospital management teams which include feedback from patients. Records seen included recommendations to improve practice. Audits are also undertaken which include interviews with patients and focus on a number of areas, one of which is that people should experience care that is focused on respect. Findings from these audit and subsequent action plans are reported to the senior nursing and midwifery group.

We were told that ward audits are also undertaken by the Matron and the findings are recorded and fed back. Senior ward staff told us that they observe practice on an ongoing basis and take action where they feel people’s privacy and dignity needs are not being respected.

Annual PEAT (Patient Environment Action Team) inspections are carried out. When compared to other NHS Trusts the hospital scored ‘similar to expected’ with regard to privacy and dignity within this outcome area in 2010 which looked at confidentiality. The trust scored ‘better than expected ’ for issues around modesty, dignity and respect.
The trust engages with the Worcestershire Local Involvement Network (LiNk) who review service provision and outcomes for people who use the service. Information was provided by the trust from an ‘enter and view’ visit which was carried out by Worcestershire LiNk in December 2010 which looked at some of the services at the Alexandra Hospital. The visit highlighted some concerns around privacy and dignity and there was evidence that the trust had developed an action plan to address the concerns highlighted to improve service.

**Our judgement**

People who use the service do not always have their privacy and dignity respected. Although we saw some people being treated respectfully, this was not consistent and people had to wait for attention after they had pressed call bells. Confidential matters were discussed where they could be overheard, so that privacy was not maintained, and some people were not given the information they needed.
Outcome 5: Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are major concerns with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

During our observations on both wards we spoke with a total of five patients and one visitor. People we spoke to were very complimentary about the meals provided to them. One person said they could not fault the food and their only criticism was that the portions given to them were too large despite them asking for smaller portions.

People said they were able to choose what they wanted to eat from a menu and one person said they were on a low fat diet and this was indicated on the menu. None of the people we spoke to said that snacks were available to them between meals.

One person told us that they had missed a meal the previous day. They were admitted at 10am and tests were carried out which meant they missed a meal. They said they were offered a sandwich six hours later. They hadn’t had the opportunity to fill in a menu card since their admission.

The people we spoke to said they were not offered hand washing before and after meals although two people said they had been issued with a pack of hand wipes which they could use.
Other evidence

The trust has Guidelines for Good Practice at Mealtimes (2009) which contain details of the action to be taken by staff to support and promote nutrition and hydration. Our findings from our visit indicate that these guidelines are not always being followed.

We observed the lunchtime routine on two wards. On one of the wards we were told that they were short staffed by one nurse and there had been no one available from the hospital ‘bank’ staff to provide cover.

Staff were given information about people’s nutritional needs at handover and we saw an example of a handover record which shown the nutritional status of each patient. For example whether they were nil by mouth, on a soft diet or did not eat red meat. On the stroke ward this also included detail of people’s swallowing capabilities where applicable.

Both wards operate a ‘red tray’ system to identify patients who may be at risk and need support with eating and drinking. However, on one of the wards we visited every patient had a red tray and it was not possible to identify which people were at highest risk and who needed more support.

Both of the wards had protected mealtimes which means that patients should be free from interruptions and that enough staff would be available to assist patients. However, during our observations we saw numerous occasions where hospital staff entered the wards and bay areas and took up either the ward staff or the patient’s attention. On bays in both wards patients were being interrupted by a medication round leaving fewer nursing staff to assist people with their meals.

We saw meals served and taken to the bedside of people who were asleep or not sitting in the right position to enable them to eat their meal. Trust guidelines state that in order to promote patient comfort and aid easier food digestion patients should be in an upright position and well supported.

The guidelines also state that in order to ensure good practice and promote the patients appetite the main course and dessert should be served separately. However, hot dinners and puddings were served at the same time and meals were seen left uncovered for up to 15 minutes on bedside tables to go cold until staff found time to attend to patients.

Some trays were not being placed within easy reach of people and food was not always presented in a way that enabled people to eat it independently. Staff were not available to assist patients to cut up their food and we saw several people on both wards using their fingers to pick up food as they had no one to help them. One person was seen trying to eat a whole tomato without assistance and began using their fingers to do so. We saw people being assisted by several members of staff with their meal and staff standing over them to assist them with eating. Nobody was routinely offered hand washing before or after their meals and hand gel was not within easy reach.

There was no evidence that people were offered alternatives as stated in the trust
guidelines if they refused a menu choice. In one case we saw a person decline their meal and staff just took it away without trying to find the person an alternative. On one ward two patients did not receive their food before the meal trolley was removed from the ward, and staff had to find them a meal.

There were some good examples where we saw some staff helping to sit people in a comfortable position to eat, encouraging people to feed themselves and offering support in a caring manner.

The trust’s website refers to protected mealtimes and states if anyone needs help at mealtimes nursing staff are available to assist. When we spoke to staff about mealtime arrangements they told us they needed more help at mealtimes. One member of staff said that they tried to treat people as they would like to be treated themselves, but this was not always possible and that they would not be happy if they were being treated in this way.

We saw instances where visitors came in at lunchtime to provide support to their friend/relative. The arrangement worked well and the friend/relative had the time to do this in an unrushed manner.

We spoke to a member of the medical team who said that for those people who can eat and drink independently there are no issues, but those that need support often face delays at mealtimes and with accessing fluids. They said that sometimes they prescribe drinking water on medication charts to ensure people get regular drinks and that this works. We saw examples of when this had been done. Ward staff said they were aware of people being prescribed drinking water and that this was done to make sure people get enough fluids and that sometimes patients are prescribed intravenous fluids too.

A ‘care and comfort round’ initiative had been introduced where staff complete a record of care provided throughout the day and night to ensure people are kept comfortable, have call bells and drinks within easy reach and that red trays are used where applicable. However, records we saw were incomplete and indicated that this was not happening as intended.

Nutritional supplement drinks had been prescribed for some people. We checked medication administration records and saw that these had been prescribed for 10am and 3pm. When we observed the lunchtime routine we saw nursing staff giving people these drinks at midday with meals and that records were signed to indicate given at 3pm. No checks were made to see how much people had drunk and we saw some drinks which were untouched or partially finished being returned to the kitchen and this had not been recorded.

Nutritional assessments were to be completed for each patient on admission and where necessary a referral made to a dietitian. Dietitians visit each ward daily and review each patient once a week. Visits were not made to the ward during protected mealtimes. Assessments were due to be reviewed weekly.

However, when we checked a random selection of records we found that assessments had not been completed for all patients and that those that had been
incomplete and had not been reviewed weekly as directed. Not all of the assessments contained details of people’s weight enabling a full assessment to be made.

One person was assessed as being ‘malnourished ‘on admission and there were no details of their weight at that time. They were not reassessed until 16 days later. The records for another person showed they were seen by a dietitian on admission and the following day and on each occasion a request had been made to weigh the person. Notes 17 days later referred to the fact that the person had not been weighed since admission.

Records of assessments and food and drink charts were kept at each person’s bedside and it was the responsibility of ward staff to complete these prior to removing people’s meal trays. We looked at records of fluid intake and output for some people and saw that some people had received no fluids for long periods of time. In some cases this exceeded 10 hours.

We asked staff if they had received training in nutrition they told us that training is limited and staff we spoke to could only recall training they received at induction to the trust. Staff told us that they felt they had good access to dieticians but access to the SALT (speech and language therapy) team can be a problem due to limited resources.

We were told that there were nutritional link nurses for each ward who were responsible for cascading information and training to ward staff. When asked, staff were initially unable to recall who these people were.

Each ward had a nutritional resource folder, which provided guidelines for mealtimes, information on food supplements and enteral feeding. The staff we spoke to were unable to locate these folders.

The trust has a High Impact Action Group ‘Keeping Nourished and Getting Well’ which aims to provide better outcomes for people. The group developed Good Mealtimes Guidelines which were cascaded to all wards. The work of the group also includes activities around privacy and dignity, reviewing the quality of meals served including sampling food and exploring the possibility of accessing more volunteers to assist with nutrition and hydration. There is also a nutritional steering group which has produced information, guidelines and procedures for parenteral feeding.

Monthly quality reviews are carried out by the divisional /hospital management teams which review the completion of nutritional assessments and benchmarks around food and drink which includes patient feedback. Where necessary recommendations are made to improve practice. Results from audits and subsequent action plans are reported to the senior nursing and midwifery group.

Annual PEAT (Patient Environment Action Team) inspections are carried out. When compared to other NHS Trusts in 2010 the hospital scored ‘better than expected’ with regard to nutrition within this outcome area which looked at menu, choice, availability, quality, quantity (portions), temperature, presentation, service and
beverages and 'similar to expected' for existence of a trust nutritional screening group, availability of equipment for measuring patients, proportion of wards that operate a protected mealtime policy and proportion of wards that are using a nutritional screening policy'.

An example of an action plan from July 2010 was provided by the trust which showed actions needed to be taken in respect of ensuring people are weighed within 24 hours of admission or during their hospital stay and that people identified 'at risk' should be re-weighed each week. Our findings indicate that this issue is still a concern.

**Our judgement**
People who use the service are not adequately supported and are at risk of poor nutrition and dehydration. Nutritional risks are identified on admission but the poor standards of review and ongoing monitoring mean that care planned may not always accurately reflect the current care needs of the people who use the service.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

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<td>- Diagnostic and screening procedures</td>
<td>17</td>
<td>1: Respecting and involving people who use the services</td>
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<tr>
<td>- Treatment of disease, disorder or injury</td>
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<td>How the regulation is not being met:</td>
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<td>People who use the service do not always have their privacy and dignity respected. Although we saw some people being treated respectfully, this was not consistent and people had to wait for attention after they have pressed call bells. Confidential matters were discussed where they could be overheard, so that privacy was not maintained, and some people were not given the information they needed.</td>
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| - Diagnostic and screening procedures    | 14         | 5: Meeting nutritional needs                                           |
| - Treatment of disease, disorder or injury |            |                                                                          |
| How the regulation is not being met:     |            |                                                                          |
| People who use the service are at risk of poor nutrition and dehydration. Nutritional risks are identified on admission but the poor standards of review and ongoing monitoring mean that care planned may not always accurately reflect the current care needs of the people who use the service. |

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider’s report should be sent to us within 14 days of this report being received.
Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

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

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

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

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

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

The Secretary of State for Health proposed a review of the quality of care for older people in the NHS, to be delivered by CQC. A targeted inspection programme has been developed to take place in acute NHS hospitals, assessing how well older people are treated during their hospital stay. In particular, we focus on whether they are treated with dignity and respect and whether their nutritional needs are met. The inspection teams are led by CQC inspectors joined by a practising, experienced nurse. The inspection team also includes an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

This review involves the inspection of selected wards in 100 acute NHS hospitals. We have chosen the hospitals to visit partly on a risk assessment using the information we already hold on organisations. Some trusts have also been selected at random.

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to patients during their hospital stay. The reviews focus on two main outcomes of the essential standards of quality and safety:

- Outcome 1 - Respecting and involving people who use the services
- Outcome 5 - Meeting nutritional needs.
Information for the reader

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Care Quality Commission

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