

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

Leighton 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	✘	Action needed
Cooperating with other providers	✔	Met this standard
Staffing	✘	Action needed
Assessing and monitoring the quality of service provision	✘	Action needed

Details about this location

Registered Provider	Mid Cheshire Hospitals NHS Foundation Trust
Overview of the service	Leighton Hospital is a medium sized district general hospital located on the outskirts of the town of Crewe. It is the management base for Mid Cheshire Hospitals NHS Foundation Trust who are a provider of acute hospital services in south east Cheshire.
Type of services	Acute services with overnight beds Rehabilitation services Urgent care services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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Summary of this inspection

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 4 February 2014 and 5 February 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 reviewed information given to us by the provider, reviewed information sent to us by local groups of people in the community or voluntary sector and 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

In addition to the dementia themed inspection this visit considered staffing levels, particularly outside of standard working hours. This was due to concerns that had been raised to us by Monitor and the local Clinical Commissioning Group (CCG). These concerns had been raised due to data that showed a possible increase of risks to patients' care and welfare at night and at weekends.

We visited the Accident and Emergency department (A&E), and three wards: Ward 7 (gastro-intestinal), Ward 15 – (orthopaedic), and Ward 14, (older people's care).

We spoke with staff in each of the clinical areas including consultants, nursing, health care, and administration staff. In addition we met with a group of five junior doctors and three matrons / link nurses.

We left comments cards and collection boxes in each of the areas we visited for a week following our visit. We received 56 returned comments cards that had been completed by relatives of patients and staff working at the hospital. 24 comments were positive, 23

contained mixed comments, 6 contained negative comments and 3 comment cards contained comments that did not relate to the theme of the inspection. Staff responses indicated that at times the quality of care provided to patients with dementia was compromised due to staffing levels.

We case tracked 10 patients identified as living with dementia across the areas we visited. We found that incomplete assessments and care records potentially impacted on the quality of the care and treatment patients received. We saw that on 2 occasions people had to wait for extended periods of time, for example 10 minutes and 20 minutes respectively, to receive support. Incomplete care records meant that in some cases it was not always possible to check that patients had their needs met.

Staff at the hospital worked with others to promote continuity of care for patients living with dementia who were admitted and discharged from the hospital. Where there was a lack of appropriate information regarding a patient living with dementia staff were proactive in gathering information about their physical and medical care needs.

We spoke with 5 junior doctors, 1 clinical nurse specialist, 1 discharge co-ordinator, 2 RGN's, 2 ward managers, 1 health care assistant and 1 student nurse. Staff told us they did not feel they had appropriate training to understand the needs of patients living with dementia. A discharge co-ordinator told us they had received no dementia training.

Although there were some quality assurance and monitoring systems in place at Leighton Hospital it was not clear how the quality of dementia care was monitored. Senior ward staff were not always familiar with the latest guidance regarding the care of patients living with dementia. This meant that available guidance was not always impacting on the quality of care patients received at ward level. Although the Trust had plans to improve the quality of support provided to patients with dementia these were still in their infancy, with some initiatives at planning stage.

Following the inspection the Trust told us that they were clear that the quality of the care provided to all patients was monitored. They submitted to us a patient feedback report and carer survey results to evidence this after they received the draft inspection report.

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

What we have told the provider to do

We have asked the provider to send us a report by 14 May 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

✘ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure patients' safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

How are the needs of patients with dementia assessed?

We visited the hospital accident and emergency (A&E) department and found that following arrival patients' immediate physical needs were assessed by a qualified nurse. This assessment determined how urgent it was for the patient to be seen and was based upon the information given by the patient, their relative or a paramedic. Following the assessment patients were directed to the most appropriate area of the A&E department for further assessment or treatment.

A&E staff explained they used an assessment document to assess the needs of all patients. This included an initial assessment of physical and medical needs, any associated risks and medical notes. We noted the assessment document did not include any prompts to gather information about patients' mental health and emotional well-being. Staff explained that if somebody on A&E was displaying symptoms associated with dementia or delirium, tests would be started to identify any physical cause. Staff told us that due to the requirements to move people to other wards within a four hour time frame the test results were sometimes received by the admitting wards.

We asked the consultant on A&E about pain assessment tools for patients living with dementia. They explained that a formal pain assessment tool was not used on A&E but that staff were aware to observe for non-verbal signs of pain.

All patients over 75 were routinely screened for dementia in accordance with national guidance. To do this staff used a Commissioning for Quality and Innovation (CQUIN) tool. Meeting CQUIN goals, including screening older patients in hospitals for dementia and referring them on for diagnosis if appropriate, leads to financial reward for hospital trusts. Where results showed that people might be displaying signs associated with dementia a

referral was made to the patient's GP for referral to a memory clinic.

When we visited ward 15 staff told us that ward rounds took place three times a week carried out by a consultant ortho-geriatrician. Staff felt this was an excellent resource. The consultant reviewed all patients that had dementia and identified any specific issues, for example, if a patient had been prone to falls, an assessment would be made as to whether there was a mechanical cause for this or whether the patient required further investigation.

On ward 15 patients who appeared confused had a mini-mental test, which was repeated after surgery. This was because sometimes people can appear confused due to pain, infection or shock so the test was repeated once the patient was stabilised to assess further whether the patient did have symptoms of dementia.

On each of the wards we visited we examined several case files and found that there were gaps in patient's general assessments. For example, on ward 15, we looked at 3 case files. In 2 cases nutritional screens, and falls assessments were incomplete. On ward 14 we found that 3 of the 4 care records we looked at to be chaotic making it difficult to access information easily. We saw that one patient's pain assessment and mental health history was incomplete.

On ward 7 we looked at the nursing assessment records of a patient diagnosed with dementia. We found that parts of the assessment were either partially completed or not completed at all. For example, the patient's Waterlow score (a nationally identified tool for identifying risk to a patient's skin integrity) had not been completed and there was no date to indicate if they had been examined to assess their skin integrity. Other omissions were noted in the patient's falls and pain assessment. Although their medical notes recorded a history of falls, and the need for pain assessment, where their daily summary recorded episodes of agitation and shouting out, there did not appear to be any consideration that this may have been related to pain. The admission assessment in this patient's medical notes was also incomplete, with gaps in the details relating to sight, communication and continence needs.

We were told by staff on all wards that each patient with dementia had a document entitled "Information about Me to help You", which when completed would provide staff with additional information about the patient's likes and dislikes and what was important to them. We found that a small number of these documents had been completed but most had not and staff told us that where patients did not have visitors the information could not always be obtained.

Following the inspection the Trust told us that a diagnosis of dementia did not automatically mean all patients required a passport. They also told us that the passports were often taken home by relatives / carers to complete and therefore not all would be available at the time of the inspection.

One comment card we received stated "Ward 14 care was exemplary. Getting to the ward was traumatic, felt as a family we had to repeat ourselves over and over. Met with respect on Ward 14. A form was completed about my mother's needs and all these needs were met. The form was left on the end of the bed for all staff to read. Felt she was in safe hands at all times."

How is the care of patients with dementia planned?

At A&E we found a 'Referral pathway' for common emergencies. This list included a

pathway for general medicine, general surgery, urology, orthopaedics, obstetrics and gynaecology, ENT, ophthalmology, paediatric and mental health. This list did not include a pathway specifically for patients living with dementia.

During our visit to A&E we observed the admission of a patient whose presentation caused staff to suspect they were living with dementia. We saw that the patient was supported into an area where staff were able to provide constant supervision. Staff explained that an immediate referral had been made to adult safeguarding due to their skin condition as this suggested they had neglected to care for themselves appropriately. This meant there could be a multi-agency approach to safeguard the patient whilst in hospital and when planning their discharge from hospital.

In the majority of cases, in each of the areas we visited, where patients had been diagnosed as having dementia, no associated care plan was available to guide staff in how to meet their individual needs. The Privacy and Dignity matron told us that prompts and guidance to support staff to care for people with dementia appropriately were readily available on the staff intranet site. However, general guidelines do not assist staff to understand how to provide person centred care to individual patients with dementia. Person centred care may only be provided if the specific dementia needs of the patients are assessed and addressed in their care plan.

We saw that for one patient on ward 7 it was identified that they needed "dementia nurse input and MHL r/v (sic)" on 28 January 2014. On the 28, 29 & 30 January 2014 the patient remained medically fit but had not been seen by the mental health team and by 31 January 2014 their condition had deteriorated again requiring further medical intervention. At the time of our visit there was no evidence of support from a dementia nurse or the mental health liaison team. Following the inspection the Trust told us that in relation to the mental health liaison assessment, the mental health team would only see a patient if they were medically fit and therefore it was not unreasonable that this assessment did not take place.

From the daily notes of another patient on ward 7 we could see that a number of entries documented they were shouting and screaming, keeping other patients in the bay awake at night. The daily notes also referred to this patient refusing medication. There was no evidence of consideration of the triggers for this distressed behaviour. There was also no corresponding care plan in place to direct staff regarding how best to support the patient to manage their distress.

One comment card received after our visit stated "During the time I have been visiting my wife - who is not a dementia sufferer - we have seen several cases of patients who have been very troublesome. Constant crying out. Sometimes great abuse - bad language - resistance has proved very testing. I have NEVER seen any such patients treated with other than with patience and gentle attention by very wonderful staff. They are special people!"

Another comment card stated "During my stay I have seen 2 patients with dementia. Overall the care they are given is great and the way they are treated. However I don't think patients with dementia should sleep on a ward with patients without. I haven't slept at all but the staff are great, considering how much they have to do."

Staff shared with us a care plan used for patients who had been assessed as having delirium. This used the PINCH ME guidelines that considered pain, infection, nutrition,

constipation, hydration, medication and environment when planning the patient's care. We noted this had not been adopted when planning care for those patients living with dementia.

On ward 14 we saw that one patient had been administered with medication "for agitation as prescribed." We found no record of the patient presenting with agitated or distressed behaviour. We also found no evidence that non-pharmacological therapies had been considered prior to the administration of medication. This meant that potentially other options had not been considered in planning the patient's care in order to prevent the need for medication to manage their behaviour.

Are patients with dementia involved in making decisions about their care?

On both the A&E ward and elderly ward we were told that where possible people and their relatives were routinely consulted about their care and their views were taken into account. We spoke with a relative of a patient living with dementia on ward 14. They told us that their mother was being looked after extremely well and said, "Staff have been excellent". They said that their mother had made a living will and had advised the nurses about it. However they felt that this information had not been shared with the nursing team and their mother's wishes had not been fully taken into account. They said that the staff had been pleasant and told us, "It's a wonderful ward for older people".

Staff on ward 7 were vague about arrangements to determine if a patient had a relative acting as Lasting Power of Attorney. Similarly staff were unsure about the process for determining if patients had made advanced directives about their care. One member of staff on ward 7 told us they would read the patient's notes and "It would be there if there if they had any advance decisions." Another member of staff said "Relatives on admission would say if there was any advance decision." However we were told by a relative that they had "Lasting Power of Attorney for my husband and I was not asked".

On ward 14 we saw in one patient's records that they had a 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) instruction. When we checked the documentation we found the capacity of the patient to make the decision was not recorded. The form stated, "husband spoken to and explained situation". This meant it was not possible to check whether the patient, and their wishes, had been considered when the decision was made. We saw another DNACPR form that had not been completed appropriately. We raised this with the ward manager who assured us they would address this with medical staff.

Relatives of patients told us they were not routinely involved with a care plan or pathways of care for their loved ones.

Are patients with dementia provided with information about their care?

Prior to our visit we checked the hospital's website to see what information we would be able to access if we were a patient planning an admission to Leighton Hospital. We did not find any information on the website related to dementia care. This meant that people living with dementia and their carers could not easily access information to allay any anxieties regarding planned or emergency visits to the hospital.

We saw a range of patient information leaflets in the A&E reception and waiting areas. These leaflets were about useful contacts, patient general health and wellbeing, and advice for carers. We saw no patient information leaflets about dementia.

Information provided by the trust following our visit explained people with a diagnosis of dementia were provided with a dementia information pack. We did not see any copies of this information pack during our inspection. Staff on the wards had limited knowledge about what information was given to patients or their carers. Staff on ward 7 told us that no information about dementia care was given to patients or their relatives on the ward. One member of staff said they thought there were information leaflets. Following the inspection further information provided by the trust explained that dementia care advisors from the Alzheimer's Society supported a permanent stand in the out-patient department. The Trust also advised us that copies of the dementia information pack were given to carers/relatives by the dementia link nurse not the ward staff. Most carers took these home to read which was why we could not find them on the wards.

We spoke with one patient on ward 15 who appeared anxious and distressed. This patient appeared disorientated and could not remember exactly how long they had been in hospital. They knew they had had an operation on their leg and could remember they had been told they were going to an intermediate care home. The patient was anxious about this and did not want to go. We saw two members of staff taking time to reassure them and explain that they (staff) would speak with their family before any decisions were made.

How is care delivered to patients with dementia?

We asked what arrangements were made when delivering care to patients living with dementia. Staff on A&E told us they would prioritise the person to ensure they minimised any unnecessary distress. Staff on urgent care, a GP led service, explained they would ensure a patient living with dementia would be directed to support as soon as possible, again to minimise any necessary distress. Nursing staff in urgent care recognised the impact the hospital environment might have on patients living with dementia and told us they would usually direct them to minors for treatment as this area was quieter with a more relaxed atmosphere than some areas of A&E.

When we arrived on ward 14 we asked the ward manager and ward sister for details of those patients who were diagnosed as having dementia. The information we received appeared unclear. When we asked for the case files of patients identified by ward staff as living with dementia we found that there was no record of a diagnosis of dementia within their care records. The electronic bed management system used by ward staff to identify the whereabouts of patients on the ward did not have any means of identifying those patients who may have required additional support due to any diagnosis of dementia. At the end of our visit to the ward we asked for definitive information about those patients on the ward with dementia. This information was obtained by going through a handover document. This showed that staff did not have clear awareness of those patients on the ward who had dementia and this may have impacted on the care they received.

On ward 15 we were told that staff were informed when a person living with dementia was being admitted from the A&E. Staff told us that they were able to escalate requests for additional support and usually healthcare assistants would be provided, if required, to offer one to one supervision.

One staff member on ward 7 told us that they did not treat patients with dementia any differently from other patients but were mindful that they had dementia and were more cautious in their approach as "We are not here to be abused" and "I don't need advice but use my own judgement. There is no dementia link nurse on the ward but there may be one on ward 5."

On ward 15 at 10.30am we saw one patient who appeared disorientated. The sign above their bed stated that they needed "syrup thick fluids, normal diet, little and often". We saw that there was a cold beaker of coffee and a plate of toast left on their bedside table. We looked at this patient's case notes, which stated they had special dietary needs and needed encouragement with fluids and strict food charts were to be recorded. We looked at the patient's fluid charts and saw that on 1 February 2014 and 3 February 2014 only 650 mls and 500 mls fluid intake had been recorded respectively. The patient told us, "I am losing weight". On both wards 7 and 15 we had concerns that care was not always delivered effectively for patients with dementia.

We spoke with another patient who was in a side room behind the main reception area on ward 15. We went into this patient's room because we could hear them crying out and trying to attract attention. This patient showed clear non-verbal signs of discomfort and was able to articulate quite clearly that her back hurt and she needed the toilet. We showed the patient how to use the nurse call bell. We remained with the patient and heard the staff having work related conversations outside their room but everyone seemed oblivious to the bell.

At 12.45 over the lunch time period on ward 15 we saw that lunch trays were served to all but one of the six patients in one bay. The patient who had not been served lunch asked the patient in the next bed to press the nurse call bell for them as they wanted their lunch. We pressed the bell for the patient but then waited for 20 minutes for any staff to come back. This patient said "I don't think they take any notice of the bells, nobody cares, you've got to ask for everything". This patient told us that they "Had hardly had anything to eat since being admitted." We looked at their fluid chart and saw that only 100 mls of fluid was recorded as having been given to the patient at 8am that morning. We looked at this patient's food charts and saw that on 2 February 2014 nothing was recorded for their lunch time meal and on 3 February 2014 nothing was recorded for their evening meal.

When staff served the lunch time meal on ward 15, we observed that they left the lid on the plate of food for one patient and the plastic wrapper on the sandwich and the foil cover on the juice carton of another patient. We saw that both these patients struggled to access the food; one of the patients had their arm in a sling and found the task especially difficult. Once the meal had been served all staff left the bay and none returned for 20 minutes, therefore no one was on hand to give these patients any additional support.

We were told by staff on ward 15 that they operated a system of red lids for jugs and red plates to alert staff where people needed support and assistance. On the day we inspected we only saw one red lid on a jug for one patient. Staff told us that six people on the ward were diagnosed with dementia or had some level of cognitive impairment. Systems to help staff identify and keep in mind those patients that needed additional support did not appear to be fully operational.

On ward 7 we looked at the case records for a patient living with dementia. This patient had a nutritional screen carried out on 15 December 2013, which identified that they had lost weight. On 31 December 2013 it was recorded that they had lost further weight and would be referred to the dietician. However, they were only seen by the dietician on 31 January 2014, by which time they had lost more weight. When the patient was seen by the dietician a management plan was put in place that included maximising oral intake, little and often, finger foods and ward based snacks. We looked at the food charts for this patient and saw that on 1 February 2014 the record showed the patient had had one quarter of their porridge and "bit of potato", half a glass of juice and a portion of ice cream

at lunchtime. Nothing was recorded to show that the patient had anything to eat in the evening. On 2 February 2014 there was no record that the patient had any breakfast or lunch and on 3 February 2014 the record stated that the patient was asleep at breakfast and nothing was recorded to show that they had eaten an evening meal.

We saw that another patient on ward 7 had a nutritional care plan in place, which required staff to monitor their dietary intake and weight. We looked at the food and fluid charts for this patient and saw that on 1 February 2014 it was recorded that the patient had refused lunch and no entry was made for any food intake for their evening meal. The chart for 3 February 2014 had no entries recorded at breakfast or lunch time and stated that the patient had refused their evening meal. On 4 February 2014 the patient's chart stated "NBM" (Nil by Mouth) at breakfast time. The chart recorded the patient had one mouthful of pie at lunchtime, 100 mls of hot chocolate and there was no entry for the evening meal. It was not evident from the patient's records whether any action had been taken to address their apparent lack of nutritional intake.

One comment card received following our visit stated, "Staff friendly. Believe there should be more staff to assist with meal and drink times."

On ward 15 we saw that one patient was being nursed on a pressure relieving mattress that was on a setting that was much too high for their weight. When we returned to the ward later in the day we checked and found that the setting was still too high and we told one of the nurses. When we visited the ward the following day on 5 February 2014, we checked the mattress again and found that the setting had still not been changed. Nursing a patient on a pressure mattress that is not at the correct setting may mean that the mattress is ineffective in reducing the risk to the patient of developing pressure ulcers, and could actually cause damage to a patient's skin.

On ward 7 we saw that one patient had repositioning charts that directed staff how often to reposition the patient. On 1 February 2014 the chart indicated that staff were to move the patient 3 hourly. Entries made on the chart indicated that staff had moved the patient's position at 10.30 hours but not again until 15.30 hours and following that not until 21.30 hours. This was a time lapse of 5 hours and 6 hours respectively. On 2 February 2014 the only entries made on the repositioning chart were for 07.00 hours and 21.30 hours. On 3 February 2013 no entries were made on the patients repositioning chart after 14.00 hours. On 4 February 2014 the patient's daily notes recorded that they had developed a grade 2 pressure ulcer.

Is the privacy and dignity of patients with dementia respected?

We left comments boxes in each of the areas we visited during the inspection, and collected them after a week. 19 care workers, 16 other workers, and 15 patient family members responded plus another 6 people who did not tell us in what capacity they were responding. Comments included:

"The nurses on the ward do their best with people with dementia. They put as much time as they can into caring with those patients. I feel the hospital needs to put more help into wards with high dementia patients. They are treated with compassion, respect and dignity."

"Care and treatment exemplary under very trying circumstances"

"Care of dementia patients is good (same level of care for all patients) however I feel more training needs to be done to teach carers the different stages of dementia, signs and symptoms. Nursing staff treat all patients with respect and dignity. Very caring nursing staff."

During our inspection we saw that a patient with dementia was brought onto ward 14 and placed in a side room. We noted that nursing staff attended to the patient's health care needs as appropriate. We looked at the patient's health record which included relevant information about the person current health status. We observed the nursing staff treating the patient with respect and dignity.

Where personal care was being delivered we saw that staff ensured curtains were used to screen patients. Conversations and interactions between staff and patients were in the main respectful and most patients reported that staff were kind and professional, including comments such as, "Everyone's been so kind to me", "Excellent", and "Can't fault them".

We were told by a relative that "My husband was treated with respect and dignity by the nurses on the ward."

We did however witness one occasion on ward 7 where a patient with dementia, standing at the nurses' station waiting for help, was completely ignored by the nurse working at the station. We waited behind the patient to ask for assistance. The nurse asked if they could help us and we explained there was a patient ahead of us. The nurse responded "Oh they are confused". We spoke with the patient who told us they felt ignored and that staff did not listen.

On ward 7 we looked at 3 patient assessment records and saw that a section was included entitled, "What can we do to help maintain your privacy and dignity", however, without exception this section was left incomplete and we could determine no other means by which staff enabled people to express how best this need could be managed for them.

The trust had a Privacy and Dignity Matron, who told us they were the lead nurse for learning disabilities, dementia, safeguarding and the Mental Capacity Act. The trust also had a dementia link nurse that was based within the integrated discharge team. We were told that each ward within the hospital had a link nurse for dementia but some of the staff we spoke to were not sure who the link on their ward was and were unclear about the roles of the Privacy and Dignity Matron and the dementia link.

The trust had a Privacy and Dignity policy that contained a specific section relating to dementia care. This section referred to the trust supporting the work of the Dementia Care Pathway group which was set up specifically to improve the quality of care for people with dementia. It also referred to the introduction of an Activity Lounge to support the drive towards personalised care and "help patients with dementia feel valued, respected and less stressed". However, staff told us that the Activity Lounge had been in operation at the time the policy was written but had since been closed and no one knew if or when it would be reopened.

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

Our judgement

The provider was meeting this standard.

Patients' 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

How does the provider work with others when providing care to patients with dementia? The A&E matron explained that written records completed in A&E were photocopied and forwarded with the patient when they were transferred to other wards within the hospital. In addition to written records staff used an electronic record system for medical patients. We spoke with five junior doctors at the hospital who were currently working on the cardiology ward, acute elderly medical ward, acute diabetic and endocrine ward and A&E. They told us that the hospital electronic patients record system was a good system and beneficial for sharing patient information confidentially and accurately. However all of the doctors we spoke with agreed that the system did not flag up if a person admitted to the hospital had dementia. Two doctors told us, "It's a good system, but a general dementia code is not available" and "Additional information like dementia is in the patient's hand written notes but not as a presenting complaint. The A&E matron stated that nursing staff liaised with the receiving ward staff to provide a verbal handover to promote a continuity of care and that information about a person's known diagnosis of dementia would be shared verbally.

Junior doctors we spoke with told us that where patients had additional information like a healthcare passport, "This is brilliant, really helpful". They explained they did not always receive information about patients admitted from care homes. They explained that they always made contact with care home staff to gather additional information about the patient but that on a night this sometimes proved difficult as care home night staff did not always have the information the doctors required. They explained that at times this left them with a dilemma about whether it was appropriate to contact the patient's families for further information, particularly in the early hours.

On ward 14 we observed the ward manager contact a family member of a patient who had been just been admitted to the ward from a care home. We spoke with the ward manager who explained staff on the ward were familiar with the patient who had only recently been admitted to the care home and who was not presenting in the way staff on the ward would expect. The ward manager explained they had spoken with staff at the care home as they had not provided any information on admission and that as the staff had not been able to provide sufficient information to help ward staff understand the changes in the patient's

condition the ward manager was hoping to get this from family members. This showed the hospital staff were actively seeking to work with others to gather the information they needed in order to inform the patient's care.

The trust had an integrated discharge team, which staff on the wards said assisted with discharges in general but were unsure what specific role they played in the discharge of people with dementia. The integrated discharge team was made up of social workers, nurses and other members of the multi-disciplinary team. We spoke with a member of the integrated discharge team who told us they worked closely with hospital staff to facilitate patient discharges.

We spoke with three representatives of the ambulance service who told us they worked with A&E staff to transfer the care of the patient to the hospital in a timely manner. Both hospital and ambulance staff told us the system had improved significantly in the past twelve months reducing delays in transferring the patient's care from the ambulance service to the hospital.

Ward staff told us that delayed discharges could occur, particularly when a patient's needs had changed and they required an alternative care home placement. Ward staff explained that this was sometimes exacerbated when changed needs had led to different funding sources for patients that required authorisation before discharge. Patients remained in hospital after they had been assessed as medically fit due to other delays as well, for example waiting for assessment by the care provider selected to deliver their ongoing care post discharge, and delays in transport. Ward staff explained they worked with others in an attempt to keep any delays to a minimum.

Are patients with dementia able to obtain appropriate health and social care support? Following an assessment to identify the need for a referral for screening for dementia the hospital faxed a referral to the patient's GP. We saw in one person's records that they had been referred to their GP for them to make a referral to the memory clinic during an in-patient stay at the hospital six months previously. There was no record on the patient's records of any diagnosis of dementia and it was not clear whether the person's referral had been actioned. In another person's care records we found they had been referred to their GP for a referral to the memory clinic on 30 December 2013. The patient had remained in hospital throughout the period between the referral and our visit. We asked staff what would happen with the referral. They explained that the patient's GP would not be able to make a referral until they returned home. This meant there was a significant gap between the person being identified as needing further assessment and receiving a diagnosis that may potentially have led to medical intervention to minimise the progression of the disease.

Following the inspection the Trust told us that they would not expect to be informed of the referral process or outcome from the dementia screening process and that this was the GP's responsibility to action. They also told us that the preference of the community mental health team who run the memory clinic (which is managed by another organisation) is to review patients when they are medically fit and have been at home to orientate themselves to their usual circumstances so that an accurate and meaningful assessment can be conducted.

We saw from care records and observations that patients had support from different health and social care professionals. This included physiotherapists, dieticians, occupational therapists and social work teams.

The wards had access to a consultant psychiatrist who was able to prescribe medication, refer to community mental health services and a community memory clinic following discharge if necessary. We were told that people with dementia were not discharged via the discharge lounge. This reduced the number of moves within the hospital for patients living with dementia with the aim of minimising disorientation during the transition in patient care.

The patients and relatives we spoke with said that it took a long time to get care in the home after hospital discharge. Ward staff told us that patients were generally discharged safely with an agreed social services care package if deemed safe for home return, or to a transitional bed in the community.

Following the inspection the Trust advised us that the discharge team highlighted that people with dementia and their families are given clear information about signposting to support services in the community. All patients identified as having support needs after hospitalisation will be referred to a hospital social worker so that advice, signposting and / or care can be arranged based on individual circumstances.

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

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet patients' needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Were there enough qualified, skilled and experienced staff to meet patients' needs? We inspected this outcome area as we had received information prior to our visit that suggested a possible increase of risks to patients' care and welfare at night and on weekends. We wanted to check the staffing levels and support that was provided to nursing and junior medical staff to allow them to safely support patients at times when senior medical staff were not present.

Information provided by the trust showed that in the 12 months leading up to our visit there were in excess of 200 occasions where a lack of suitably trained and skilled staff on duty was recorded across all departments within the hospital. Of these there were 49 occasions where an impact of "low harm" to patient care was recorded. All other occasions showed an impact of "no harm".

During our visit we spoke with four junior doctors, four staff on ward 14 three staff on ward 15, three staff on ward 7 and four staff on A&E.

The doctors told us that there were different levels of support for them. They told us there was an A&E consultant available at weekends between 8am and 6pm and there was nobody senior in the hospital at night however they could be easily contacted by phone using the on call system.

They told us that the lack of junior doctors had a significant impact on other ward areas and said, "The lack of junior doctors often impacts on patient care, we're very stretched" and "I don't necessarily feel as though I've given people the time they need" also "We're spreading ourselves thin and this is more to do with time constraints". Also, "There is always a Registrar, they are helpful when needed. There are not enough hands. We need more hands."

The junior doctors we spoke with told us they felt the current issues would increase as there was a planned reduction of junior doctors in the next intake. They told us, "We are

stretched. We are doing jobs that are F1 (junior doctor) we feel we are not progressing". They also told us, "We feel we are listened to, but there are not enough junior doctors ultimately", and, "The nurses are stretched as well. There are more nurse practitioners in place but it is a long process to train them. They help the acute take but additional doctors are needed."

Following the inspection the Trust told us that the Deanery specify the number of junior doctors the Trust will receive which is never the same number they submit as being required. As a result of their feedback, the Deanery have agreed to fund one extra post and the Trust is hopeful they will have input from 4 new GP F1 posts that will do hospital based on call. They also told us that when gaps are left by the Deanery, the Trust very actively tries to recruit to these and has had some success with international recruitment.

Ward 14 staff told us that the ward had reopened that day following a 7 day ward closure due to Noro-virus. They told us staffing levels on the ward had improved "Ten- fold" and had benefitted from an additional member of staff.

When we visited ward 15 we were told by staff that the ward was often not fully staffed. We were told that acuity and dependency scores were completed on a daily basis and this had resulted in the staffing establishment being increased. This meant that the staffing establishment for the ward was set at five qualified nurses and four healthcare assistants in the mornings, four nurses and four healthcare assistants in the afternoons and two nurses and three healthcare assistants overnight. However, staff said that on a fairly regular basis these figures were not achieved, due to staff sickness or staff being moved to other wards. On the day of our inspection only four nurses were working on the ward, instead of five, and we were told that the previous weekend, there had only been two nurses for the whole ward. This meant that there was a ratio of one nurse: 16 patients, instead of the set ratio of 1:8 that had been determined as required by the acuity and dependency tool. We were told that attempts had been made to arrange for agency nurse cover but this had not been successful.

We spoke to senior managers about this and were told that on the surgical wards acuity and dependency were assessed every day and that shortages of staff were escalated. Despite this there were times that wards suffered from shortages of staff and this had been exacerbated by a recent outbreak of norovirus.

Staff on ward 15 told us that during the week a range of additional staff were available, such as a housekeeper, ward clerk, discharge coordinator, physiotherapists, and occupational therapists. Staff informed us that these staff did not work at weekends, therefore to some degree there was a reduced service.

Staff also told us that after 5pm and at weekends cover by the medical staff was reduced. This was because whilst a doctor covered the ward during the day, after 5pm and at weekends they had to cover the elective orthopaedic ward and the ED as well so the time they spent on ward 15 was limited. Junior doctors we spoke with told us this impacted on patient care stating, "This does impact on patient care for example if patients need a fluid bag, this is delayed at weekends and bank holidays"

On ward 7 the ward manager told us that the staffing establishment had recently been increased in order to meet a satisfactory nurse to patient ratio. The manager said that this was a big improvement and she felt enabled the staff to deliver a better standard of care.

Assessing and monitoring the quality of service provision

✘ Action needed

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 not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

How is the quality of dementia care monitored?

Staff we spoke with told us of initiatives that were planned to enhance the care provided to patients living with dementia. These included the use of volunteers to facilitate activities. This was at the implementation stage at the time of our visit. We were also told that the Trust had developed a new quality strategy which included dementia and that this would be published in April 2014. The trust forwarded a copy of the draft quality strategy that included eight statements of intent to enhance the quality of care experienced by patients living with dementia.

We asked the Governance Lead about Board awareness of dementia issues. We were told that the complaints review panel was chaired by a non-executive member and complaints were reviewed to look at trends and themes in all areas. The Governance Lead gave us an example of how this worked in practice, saying that there had been some complaints about ward 14, so two members of the Board had visited the ward and fed back to the patient experience lead and also to the Board. It was not clear how complaints regarding the care of patients living with dementia were identified in order to identify learning and improve the quality of care for patients with dementia.

At the time of our visit the trust was not using current guidance regarding best practice for patients with dementia to inform its monitoring activity. Following our visit the trust forwarded information about the arrangements in place to ensure that guidance published by The National Institute for Health and Care Excellence (NICE) will be considered and implemented at the trust. This included the quality standards related to dementia care. The majority of staff we spoke with at ward level were not aware of current guidance and quality standards regarding dementia.

When we asked about a dementia pathway being in place we were informed by the dementia lead that the hospital did not have one. They told us one had been considered but it was felt not to be appropriate for people living with dementia as "They are all so

different". This meant the Trust did not have a dementia care pathway in place in order to guide staff and to monitor whether patients living with dementia were supported in the most appropriate way.

However following the inspection the Trust told us that whilst a pathway for dementia had been considered, it was felt difficult to be prescriptive due to the individual needs of a patient with dementia. Therefore, a decision was made to place user friendly dementia prompts and guidelines on the intranet. All staff can access the dementia care guidelines which contain a range of information to help support them caring for people with dementia and their carers. The guidelines look at the first 24 hours of admission, the inpatient stay and discharge planning.

Following the inspection the Trust provided information to show that across the Trust 1511 staff had received training in the period April 2013 – January 2014. This figure comprised of a mix of Essential and Mandatory update training which was held bi-annually, induction training for new starters and specific dementia training that had been delivered to 49 staff.

However all staff we spoke with including nursing and clerical staff told us they had had either limited or no dementia awareness training. Three junior doctors confirmed there was a lack of dementia training. They told us, "Yes there is dementia awareness training. This is nothing formal but we tend to get our knowledge about this from the news or radio 4. Nothing is provided by the Trust". However senior management within the Trust informed us that they monitored the numbers of staff who had completed dementia awareness training and that the training had been completed by the majority of staff. As part of the inspection we asked the trust to provide us with details of staff training.

Following our visit the Trust forwarded the programme for 'Bi-annual Essential and Mandatory Update' training that showed 45 minutes was allocated to 'safeguarding children and adults (including dementia awareness)'. There was no evidence that the quality or effectiveness of dementia awareness training had been monitored to ensure it provided staff with the skills and knowledge they needed to adequately support patients living with dementia.

How are the risks and benefits to patients with dementia receiving care managed? Staff working on A&E explained they considered the risks to patients living with dementia when considering arrangements for them to return home when admission was not required. The A&E manager told us there had recently been a complaint regarding a patient who had returned home in the early hours following a visit to A&E. They explained that staff considered the impact to the patient living with dementia of remaining in an unfamiliar environment against other risks such as outside temperature or returning home without support. They told us that where a patient had capacity to choose to return home this would be facilitated. Where patients did not have capacity a best interest decision was made that usually resulted in the patient being admitted to hospital overnight to support a safe return home.

We looked at how serious incidents were managed and reported. We were told by senior managers at the trust that where incidents occurred, staff completed an incident form which went to their line manager. The incident was then reviewed and investigated and was then sent to the Integrated Governance Department, where it was reviewed again. Once the case was closed it would be reported on the National Reporting and Learning System (NRLS). We asked how the trust could be assured that staff were able to learn from these incidents and were informed that once reported to NRLS the manager should

then be feeding back the outcomes and learning to staff. However, we were told that this didn't always happen and senior managers acknowledged this was an area of weakness. Following the inspection the Trust told us that they also disseminate lessons learned through the divisional governance processes and the post graduate medical centre for junior medical staff.

We were told that various methods were used to disseminate information and learning from serious untoward events, for example "Lessons Learned" fliers were widely distributed across the trust and cases were reviewed at audit meetings. However, when we asked nursing staff and junior doctors about a recent "Never Event" involving a medicines error (A Never Event, is a serious mistake that should never happen), 3 nursing staff had not heard about it.

On ward 14 we found the ward was bright and airy. There was signage directing patients to toilet and bathroom areas. The ward manager told us work was planned to adapt the ward to make it more appropriate to support patients living with dementia. However they told us they did not think the ward had the most appropriate layout and that there were other wards in the hospital where the environment would best support patients living with dementia. We asked if this information had been fed back to the Trust and were assured that it had.

Although information was collated regarding incidents of aggression, verbal abuse and physical assault involving patients living with dementia the trust did not provide us with any evidence that the information was analysed to improve the care provided to people with dementia. When we analysed the information provided we found that of 85 recorded incidents, 57 had occurred between 7pm and 7am. This showed the risk of incidents doubled overnight but there was no evidence that monitoring by the trust had identified this trend in order to consider action to reduce risks.

Following the inspection the Trust advised us that violence and aggression (V&A) information is reviewed at a high level at each V&A forum. At the last meeting, it was recognised there was a trend in increased numbers of dementia related incidents and these will be discussed at the dementia operational group to discuss where these incidents are occurring, possible triggers and action required to support patients, carers and staff.

Are the views of patients with dementia taken into account?

In each of the areas visited we saw comments cards were used by the Trust to gather the views of patients and visitors.

The matron on A&E explained that comments and complaints were considered and the Trust used a "You said, we did" approach to responding to feedback. They gave an example that following a complaint that a patient had not received anything to eat and drink whilst they had attended A&E. They told us that following this complaint a system had been implemented where the housekeeper or designated health care assistant routinely checked for those people requiring something to eat and drink whilst in the A&E department.

Senior staff told us that the dementia link nurse from the integrated discharge team gave an information pack, which included the document "Information About Me to help You" to all family carers of people with dementia, when they were admitted to the hospital. We were shown an example of the pack, which also included a book of information from the Alzheimer's society and a survey for people to complete to enable them to give their views

about dementia care at the trust. Surveys formed part of the CQUIN process and we were told that the information was than shared in forums such as the Dementia Operational Group and the Dementia Care Strategic Group.

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010
Treatment of disease, disorder or injury	Care and welfare of people who use services
	How the regulation was not being met: The provider did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of - (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and treatment in such a way as to reflect published research evidence and guidance. Regulation 9
Regulated activities	Regulation
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010
Surgical procedures	Staffing
Treatment of disease, disorder or injury	How the regulation was not being met: The service did not safeguard the health, safety and welfare of service users by ensuring that there were sufficient numbers of suitably qualified, skilled and experienced persons, employed for the purposes of carrying out the regulated activity, at all times. Regulation 22

This section is primarily information for the provider

Regulated activities	Regulation
Diagnostic and screening procedures	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Assessing and monitoring the quality of service provision</p> <p>How the regulation was not being met:</p> <p>The service did not protect service users and others from the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to assess and monitor the quality of services provided or to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. Regulation 10</p>
Surgical procedures	
Treatment of disease, disorder or injury	

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 by 14 May 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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