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

Queen Alexandra Hospital

Queen Alexandra Hospital, Southwick Hill Road, Cosham, Portsmouth, PO6 3LY

Tel: 02392286000

Date of Inspection: 13 March 2014

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

- Care and welfare of people who use services: Met this standard
- Cooperating with other providers: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
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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 13 March 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, received feedback from people using comment cards, reviewed information given to us by the provider 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

During this inspection we visited 15 wards and other areas where patient’s received care within the hospital.

We looked at the quality of care provided to support patients who were living with a diagnosis of dementia. We looked at the support they received to maintain their physical and mental well-being as part of a themed inspection programme.  This programme looked at how providers worked together to provide care to patients with dementia, how the needs of patients in relation to their dementia were assessed, planned and delivered and how the trust monitored the quality of the care, treatment and support provided to patients with dementia during their hospital stay.

We spoke with 13 patients with dementia during this inspection. We also spoke with five relatives and approximately 40 staff, including the chief executive officer, acting director of nursing and deputy director of nursing.

For all the patients we saw and records we reviewed dementia was the secondary diagnosis and not the main reason for admission to hospital.

We were provided with information from the trust that told us that all areas within the
hospital had an appointed, "dementia champion". We were told that these staff had undertaken additional training about dementia and were responsible for cascading any new developments through to their teams. We were told this was working well in some areas although others had only just received the training. We saw that in all the areas we visited a member of staff had been designated as a dementia champion.

Nursing staff we spoke with told us that they are required to undertake annual essential skills days and that these have included sessions about dementia. They also told us that they are required to undertake a competency assessment, which included questions about dementia and the care people would require.

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

More information about the provider

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

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

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<th>Care and welfare of people who use services</th>
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<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
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Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

How are the needs of patients with dementia assessed?

We saw that appropriate assessments in relation to patients physical health needs were undertaken. These included past medical history, presenting symptoms, and an element of social needs. For example, information was recorded to identify who the patient lived with and the support they received prior to admission. We saw where patient's had a diagnosis of dementia that this was noted in the medical assessment information completed on admission to the hospital. However we often found that these assessments did not provide any clear information about how the patient's dementia presented, or the support they required in relation to their dementia.

We were told by staff that all non-elective patients over the age of 75 admitted to the hospital underwent a dementia screening assessment and this was the responsibility of the doctors to complete. The trust also provided us with a copy of their, "NICE Quality standards – Dementia Gap Analysis", dated November 2013 which confirmed that this was the expected protocol in the hospital.

This screening ensured that patient's cognitive functioning was appropriately assessed. We were told that this assessment supported the decision making process and helped to identify the need for referrals for additional support for patients. For example, referrals could be made to the older person mental health team for review of a patient's mental health or to occupational therapy staff to support with equipment and aids to support patients with their activities of daily living.

We saw that the initial assessment on admission included an abbreviated mental test score (AMTS). We also saw some examples of cognitive and mental health assessments over time, particularly where interventions such an operation, may temporarily affect a patient's cognitive functioning. Staff we spoke with told us that screening had just moved from a paper based system to an electronic system and all staff were aware of the need to
undertake these. We found that the majority of the 15 areas we visited had routinely completed the screening assessment. However, the provider may find it useful to note that for a small number of areas we could find no records that these had been completed.

We were given conflicting information about the timescales the trust have set for these to be completed by, some staff told us this was to be completed within a 24 hour period, some told us 48 hours and others told us 72 hours. We were told that when these had not been completed they were flagged up on the VitalPAC system as having not been done and doctors were prompted to do these.

We saw that patient's cognitive functioning was assessed, where appropriate, pre-operatively. This enabled staff to be aware of and be able to identify quickly if the person was suffering from any post-operative complications, for example an infection which may have influenced their ability to maintain their own safety.

We were told and saw that nursing assessments were undertaken on admission. The nursing assessments were based on activities of daily living (ADL). These assessments identified a patient's level of function in different areas such as mobility, mental health and communication. We were told that this process included discussion with the person or the family/carer, if appropriate, to gather as much information about the patient and how their dementia affected them as possible. For example, what patient liked, didn't like, what caused them anxiety and how to support this. However, nursing assessment records we looked at did not reflect these discussions. For example, for one patient we were told by staff that going for a walk or reading a newspaper supported them to feel less anxious. For another person we were told by staff that sitting out of bed looking out of the window helped them. Whilst staff were aware of this information we did not find this information recorded in the nursing assessments or care plans.

We looked at how patient's holistic needs were assessed by a range of healthcare professionals. We noted that physiotherapists, dieticians, speech and language therapists (SALT) and older persons mental health (OPMH) responded quickly to referrals to assess people and offered advice to nursing staff about the support the patient required. We noted that this was clearly documented within the medical notes but had not always been incorporated into the nursing care plans. For example, for one patient we saw that SALT had assessed them on 11 March 2014 and recommended normal fluids and a normal but soft diet. We saw that this was being provided to the patient by staff, however, we noted the nursing care plan stated that the patient was to be given stage 1 thickened fluids and a fork mashable diet and was dated 4 March 2014. Staff we spoke with told us that any changes were always shared verbally and informed the handovers received at each shift. Handover records we reviewed were detailed and all staff were involved in these.

How is the care of patients with dementia planned?

Staff told us that the trust was in the process of developing a dementia pathway to support the effective planning of care for patients with dementia.

We were given examples of how care was planned in an acute care environment to support patient’s recovery in a way that took into account the care they needed in relation to their dementia.

We saw that a number of methods were used to inform the planning of patient's care. This included both written records from regular ward rounds and other meetings between the
members of the multidisciplinary teams (MDT). Multidisciplinary care records seen showed that care planned was responsive to patient's changing needs in an acute environment.

On one ward which provided care to patient who had sustained a fractured hip. A consultant and matron told us about an initiative of enhanced therapy, which meant that additional therapeutic time was given by the multidisciplinary team including, physiotherapists and occupational therapists to patients with dementia. We were told that this took into account that patients may need additional time due to their cognitive impairment. We were told by a ward sister that this meant that if patients did not feel up to engaging in a therapy session staff had the time to try again later. Staff had time to interact with patients in a way that took into account their individual needs. A consultant told us that this initiative had reduced the average length of stay of patients admitted to the ward.

We saw that magnetic boards or signs above patient's bed that provided pictorial information to indicate to staff the type of support that patients needed. For example, support with eating and drinking. We were told that the trust used a "forget me not" picture, placed above a patient's bed which informed staff that the patient was living with dementia. The provider may find it useful to note that whilst all trust staff were aware of this and knew what it meant, some other agency staff were not.

Following the nursing assessment, nursing care plans were developed. We saw that some patients had care plans that identified that the patient was living with a diagnosis of dementia. However, we noted that these did not provide any information about how the patient's dementia presented. The guidance about the support the patient needed was generic and lacked personalised detail. For example, for one patient we saw that the support to be provided told staff to use short simple English, provide reminders as needed and keep the patient's next of kin updated. For another patient who was presenting with confusion we saw that the care plans stated, "Patient confused and sometimes refusing care". This told staff to provide support whenever possible and maintain the patient's privacy and dignity. We found that the care plans did not include how the patient's dementia affected them, what may be the triggers to any anxiety or confusion and what support was needed. We also saw mention of words such as "confusion", or "restlessness" in the care records of patients with dementia, but the records did not describe how the behaviour showed itself, so that it could be accurately assessed.

We saw for patients who presented with behaviour that challenged, a monitoring record was in use. However, we found that these were used to report the behaviours shown rather than to review any incidents, identify triggers and plan on-going care.

We were told and saw very detailed handover sheets, which were provided to staff when they commenced their shift. This included a summary treatment plan. The detail on the handover sheets seen corresponded with what staff told us about patient's needs. Staff we spoke with told us that the handover sheets informed care delivery and how to meet the needs of people on a day-to-day basis. We could see from handover sheets, observation and talking to staff that care was consistent and safe, but it was difficult to assess from the records how particular care needs were being monitored effectively over time.

All staff we spoke with were aware that, for patients living with dementia, it was important that planning for their discharge from hospital started at an early stage. Nursing staff and doctors told us that when a patient is admitted, if they feel at the time of admission additional support may be required on discharge, "section 2" referrals are made to adult social care (Section 2 referrals involve alerting the adult social team to the patient's
admission). We were told that when the patient was medically fit for discharge a “section 4” referral made to adult social care (Section 4 referral we were told included alerting the team that the patient was medically fit for discharge).

All staff we spoke with told us that patients were not discharged until such time as appropriate support arrangements had been made for them. We were told that in some situations this could take a number of weeks however, the patient would not be outlied’ (this means they would not be moved to another available bed outside of the ward they have been receiving care in).

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

We found that patients were involved in making decisions about the care they received on a day to day basis within the hospital environment. We saw and were told of a variety of tools to support this decision making.

Staff we spoke with told us about how they engaged with a patient to allow them to understand and inform them to make decisions. They told us that they always discussed with the patient the treatment that they required and would do this in a way in which the patient understood. For example, for one patient we saw that they wanted to go home, however this was not safe for the patient at the time of our visit. We saw how the staff worked the patient and their family to help them understand the risks involved in making the decision to go home without additional support. We saw that this included discussion with the patient, involvement of the MDT and identification of the support available to the patient, in order that they could make an informed decision about their ongoing care.

In the multidisciplinary records we looked at, we found that patients and their representatives were consulted about care and informed of any changes in their condition. One relative commented, "We are kept informed…we rely on them to tell us…".

We saw that the nursing care planning document included a sheet to complete to indicate that either the patient, or their representative, had been involved in the development of the care plans. However, we noted that of the records we reviewed across a variety of sites in the hospital, these had not been signed.

We saw evidence in people’s records and found in discussion with staff that mental capacity assessments were carried out when a patient was unable to make a specific decision. We saw that when a patient lacked capacity to make a decision, best interests meetings were held, which involved patient’s representatives as well as health and social care professionals.

From observation and records seen patients were supported to make choices that they are able to make. Where patients were not able to make decisions appropriate arrangements were in place to ensure that patient's views and experiences were taken into account.

Are patients with dementia provided with information about their care?

Information was available for patients. We saw that there were posters and leaflets on the wards to provide advice and guidance to patients and their families.

Within records we looked at there was evidence that where a patient may be unable to understand information, time had been taken to consult with family members. For
example, for one patient who had been recently admitted to the emergency department, records showed they had made the staff aware that they were unable to provide information about their needs. They had also informed the staff at the hospital that their carers would need to be involved. We saw that no treatment had been provided until the discussion with the carers had taken place and the person had been provided a clear explanation of the treatment that was required. We saw for this patient additional written information had been provided to support them to understand how to manage their condition. This information had also been provided to the carers.

During our visit we saw that patients were provided with information that they could understand about their care. We saw that leaflets and information sheets were available to help patients understand their care. We saw that staff provided clear explanations about what they were doing as they provided support to patients. However, one patient we spoke with told us whilst their plan of care had been reviewed with them, "The language used is too medical for the layman". Nine people we spoke with told us that they felt staff communicated effectively with them and if anything was unclear they could ask staff to explain and would be confident of a response.

How is care delivered to people with dementia?

Throughout our visit we undertook SOFI observations. We did this to understand the experiences of patients living with dementia in the hospital. We observed both positive and negative experiences for people using this method of observation. For example, we observed very compassionate, understanding, calm support being provided in a way that the person responded to positively. This included gentle distraction techniques, encouragement and allowing the person the space and time to do what they needed. However, we also saw how one patient was prevented from leaving their chair and that their meal appeared to be a rushed and unpleasant experience. The provider may find it useful to note that most trust staff showed compassionate care, there was this instance of unpleasant experience.

In addition to our SOFI observation we spent time generally observing how patients were supported. We found that the staff were kind in their approach, spoke to patients with compassion, empathy and at a pace that allowed for the information to be processed and understood.

Staff we spoke with were able to provide us with a clear insight into the patient and how living with dementia affected them. They were able to tell us about how they supported patient to feel safe and less anxious. This included examples, providing additional staff where required, ensuring people families were engaged, allowing visitors outside of the allocated visiting times.

Further examples included; ensuring a patient's handbag was in view so they did not become anxious, making sure a patient was seated out of bed because they did not like to stay in bed, going for walks and getting newspapers and reading these with the patient.

The staff we spoke with throughout the visit spoke knowledgeably and enthusiastically about their roles and their commitment to make a difference to the care of patient with dementia. Staff had awareness of the NICE standards relating to dementia care and talked about working with patients with dementia, giving time to interact and listen to their needs and concerns responsively. Staff told us that every effort is made to provide continuity of staff and environment for people with dementia. We were told by most staff that they had
undertaken training in the care of patients with dementia to equip them with the skills to meet and respond to patient's needs. For some staff this included simulation events and face-to-face training. We saw that this training was reflected in the manner in which staff supported patients, for example by explaining clearly what they were going to do prior to delivering care. Care was taken to sit on a level with patients and to talk to them supportively. Time was taken to give patient encouragement where needed.

We saw that in some ward areas, the environment was being developed to effectively meet the needs of patients with dementia. In one area specifically for patients with dementia needs we saw that the environment included a memory lane and comfortable reminiscence area, with a small café. On this ward we also saw there was special flooring and the use of colours, to distinguish different areas of the ward with hand rails and clear pictorial and written signage. We were told there was a planned programme to incorporate this into other areas of the hospital.

Is the privacy and dignity of patients with dementia respected?

Staff we spoke with recognised that acute areas of the hospital could at times present challenges in supporting the privacy and dignity of patients with dementia. For example, acute areas where patient's care needs required an urgent medical response.

We saw that patients were supported in a way that was considerate of their rights to be treated with respect and dignity. Curtains were closed when providing personal care. Care was taken to talk to patients discreetly in the busy ward environments. Staff were heard to use patient's preferred name and staff recognised that the forgot-me-not symbol was in place to discreetly identify that the patient required additional support in maintaining their own privacy and dignity.

Information about patient's needs was provided in a way that was sensitive and caring in language that patients could understand.

All staff we spoke to showed an awareness of protecting patient's privacy and dignity and treating them with respect.
Cooperating with other providers

Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Do providers work together when providing care to people with dementia?

We looked at the records of people at varying stages of their admission, their treatment or their discharge from the hospital environment.

When people were admitted to the hospital as an acute admission we saw that staff recognised people with a diagnosis of dementia required additional support to ensure their needs were met whilst in hospital. For example, one person was unable to provide information to ensure staff were aware of all their needs so staff had made contact with the person's relative and carers to help inform this process.

We saw that another person had clearly told medical staff on their admission that, "I do not know why I am here or what is wrong with me." Records showed that medical staff had then discussed the ongoing care and treatment of this person with their family and included the person in these discussions.

Staff in the emergency unit told us that sometimes care homes provided information about a person on their admission although this was often not the case and they felt that this could be improved. Staff on this unit told us that they often communicated with residential and nursing homes to ensure they had up to date information for people with dementia. We saw records which showed that this happened.

During our visit we saw evidence in all ward areas that an integrated multidisciplinary team approach was used to provide care for people living with dementia. We saw that people had access to, and assessments from, a wide range of health care professionals within the hospital including; occupational therapists, physiotherapists, dieticians, speech and language therapists, tissue viability nurses, older person's mental health services and psychiatry liaison teams, community care teams, social care workers and dementia specialist nurses.

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

On two wards which we visited we saw that a tool called, "This is me" was completed for people with a diagnosis of dementia. This tool provided staff with information about the needs of a person with dementia when they moved between services. We were told that the document would be sent home with the person, so that should they need to move between care environments again the document could be taken with them. This would enable staff who would be caring for them to have details of what matters to the person, their background and social needs as well as how to best communicate and provide care for them.

We saw that the hospital had clear discharge processes for people with complex health and social care including those with dementia. Staff we spoke with recognised the need to ensure comprehensive plans were made for people with a diagnosis of dementia being discharged home to the community environment. This meant that staff needed to be aware of the multiple providers available across the geographical area to support people. Staff told us that to reduce the re-admission rates of people with dementia to the acute hospital setting it was important to ensure the support network available to them on discharge was robust and effective.

We saw examples of where the hospital was cooperating effectively with providers in the community so that people's needs were met seamlessly. For example, one social worker told us of one person living with dementia who was planning to go to their own home environment within 48 hours of our inspection. This person and their family had requested that they were supported in their own home with a package of care provided by a domiciliary care agency (DCA) provided by the local authority. A discharge planning meeting had been arranged with the DCA, the social worker, the person and their family to ensure that they were all aware of the needs of the person on discharge and the risks associated with this.

We saw that staff from other local providers worked on site at this hospital to support an integrated approach to the discharge process for people from this hospital. Staff from two local NHS community service providers and two local authorities worked at the hospital and were an integral part of the discharge team. A local NHS mental health care provider also worked closely with staff to support people with dementia who were admitted to the hospital.

We saw that voluntary services and charitable organisations were available to support people's needs in this hospital. For example, the Red Cross charity were based within the hospital setting and were able to advise people about services available to them on discharge and support people with domestic tasks on discharge.

Are people with dementia able to obtain appropriate health and social care support?

We saw that ward based health and social care professionals supported people in providing a comprehensive assessment of their health and social care needs whilst in this hospital. For example, on two wards we spoke with social care staff who told us how they worked closely with their health care colleagues to support seamless care for people when they were discharged from the hospital.

We saw how medical and surgical teams of staff worked together to ensure a holistic
approach to people's care and welfare. For example, on one ward we spoke with a consultant who worked with older people undergoing surgical procedures. They ensured that all of their health needs were assessed including pre-disposing medical conditions such as dementia.

Specialist nurse practitioners in the hospital worked with older people with dementia in ensuring their medical and surgical needs were met.

On all of the wards we visited staff told us that there were effective links with the older person’s mental health teams.
Assessing and monitoring the quality of service provision

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

Our judgement

The provider was meeting this standard.

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

The provider had 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.

Reasons for our judgement

During this inspection we looked at how the hospital monitored the quality of the service it provided. We looked to how this was managed in relation to people living with dementia and we looked to see that systems for other parts of the hospital were in place.

How is dementia care monitored?

We were provided with evidence which demonstrated auditing was taking place in relation to dementia care at ward level. The trust had undertaken two audits on dementia: the first was the result of the national audit of dementia and showed a comparison between the trust and national results. This audit was led by Royal College of Psychiatrists (RCP) National Dementia Audit. We were provided with a copy of the last report dated February 2013 and noted that the hospital performed well in the majority of the areas assessed, compared to national averages. We spoke with the chief executive and the acting director of nursing who told us that the hospital intended to take part in the next national audit commissioned by the RCP. The second audit reflected how the trust performed on the National Institute for Health and Care Excellence (NICE) quality standards for dementia. The NICE guidance on dementia were reviewed and gaps identified for the trust.

We saw that the trust had implemented a dementia strategy. The strategy was being led by a dementia steering group and was developed taking into account the national audit on dementia and the review of the NICE guidance on dementia. The steering group was advising the trust on the improvements that needed to be made in relation to dementia care. The role of the steering group was to ensure dementia care was coordinated across the trust. We saw that the group had set up priority actions for the year 2013-2014. During our visit we were provided with an update on these priorities. The acting director of nursing told us the trust was on target for completion of those priorities as identified in the March 2014 update. For example, one of the trust's priorities was to fund ward refurbishment to ensure the wards were "dementia friendly." We found two wards had
been completed and there were further plans to extend the refurbishment of other wards where patients with dementia would be cared for.

The group had also begun work on a dashboard of measurements on areas for improvement for dementia. We found the initial work had been completed. We were shown an example of what this dashboard would look like and the trust was undertaking some revisions to this. It was envisaged that this dashboard on dementia care would be shared as part of the overall quality indicators to the trust board. This would allow the trust board to ask relevant questions on dementia care.

The steering group had also initiated a new way to train members of staff in dementia. The training was a simulated laboratory where members of staff would come and have practical hand on experience of dementia. Whilst the training in this area had just begun (September 2013) we spoke to members of staff who had attended this programme. They told us that it changed their understanding of dementia in a more practical and meaningful way.

In November 2013, the trust began its own quarterly internal quality assurance inspection visit. These were peer observational visits where the area visited were provided with feedback on key areas such as staffing, discharge, infection control and others. In January 2014, the key area identified was dementia care. We found that issues identified that members of staff needed more awareness of dementia. The areas visited had been provided with the results of the visit and we were told an action plan from them would be forthcoming (deadline for this was 1 April 2014) to the head of governance. We were shown examples of action plans from other key areas.

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

We saw that there were safe systems in place to manage identified risks such as the management of falls, which included a falls pathway, the completion of a falls risk assessment, incident forms and post fall monitoring. In addition there were investigations took place and lessons learned included the use of preventative strategies such as fall alarms. The trust were monitoring trends in relation to falls occurring in a ward area.

We found that the trust had effective monitoring systems were in place. At the strategic level, there was evidence that learning from incidents took place and appropriate changes were implemented. We reviewed the incident reporting system in place at the hospital and were provided with four reports. The reports we saw demonstrated that appropriate incidents were reported. At the ward level, we saw on one ward that incident forms were completed electronically. We saw that the ward sister reviewed all forms and that this included highlighting any actions to minimise the risk of reoccurrence or practice development. We also saw how incident forms were completed electronically and members of staff told us about their responsibility to report any adverse incidents. We saw that when an incident occurred, steps were taken to investigate causal factors in order to minimise further risks and inform best practice. For example we saw that a detailed root cause analysis had been completed when a patient had sustained a pressure sore and the circumstances investigated to determine that, in this case, the sore had been unavoidable. A matron told us that following a receipt incident, investigation and learning outcomes, this had resulted in additional training for staff.

We saw how a commitment to reduce pressure sore occurrence has been implemented and is being used to develop preventative practice and reduce the occurrence of avoidable
grade 3 or 4 pressure ulcers. A matron told us about the "Aim for Zero" campaign. We saw how aspects of the initiative are working in practice, including the use of pressure-relieving equipment, completion of detailed checks of skin integrity and the individualised planning of care to high risk patients. The matron told us about how individual wards had championed aspects of the initiative, so that together the wards shared and disseminated evidence-based best practice.

We found all serious incidents had a root cause analysis undertaken and that the results of and learning from these were disseminated throughout the trust. For example, we saw all serious incidents and their outcomes were reviewed by the trust board on a monthly basis through a patient safety and quality report.

Are the views of people with dementia taken into account?

We found the trust board undertook its own listening exercise to hear patient stories at its open trust board meetings every month. This gave the board an opportunity to hear experiences of patients who used the service. In January 2014, the board heard the story of a patient with dementia. We spoke with a non-executive director who told us that these stories gave the board a, "Real feel of what patient care was all about."

We spoke with ward staff who told us that to monitor the care they were providing to people living with dementia they asked people for feedback. We were told that whilst this had just begun on the wards, the comments had given them further insight into how these could improve patient care. We spoke with two ward managers who told us they used this as part of their on-going monitoring of quality on their ward. For example, they shared these comments with members of staff in their monthly meetings and ensured lessons learned from these led to improvement in care.

We saw that on most wards that a, "Friends and Family Test" had been initiated. This involved asking patient's on their day of discharge how likely they were to recommend the ward to friends and family. We saw that the results from across the hospital, including dementia wards, were collated and discussed at the trust board. The chief executive told us that this was a very valuable tool in having the wards own the care provided to their patients. We found where negative scores were received, there were systems of support including using the dementia champions on each ward to drive improvements. We spoke with three dementia champions who told us that they were well-supported in this role.

Another ward manager described how each ward goes through a process of assessment each year and their ward had achieved a 'gold' status, which is the highest level, in terms of key outcomes which are measured in line with the outcomes from the essential standards of quality and safety. The chief executive and the acting director of nursing told us how through this process of internal assessment they are raising the performance of wards in a developmental and supportive way.

The provider took account of complaints and comments to improve the service. We spoke with members of staff from the complaints department and they told us they monitored complaints, comments and plaudits received by patients and relatives. We saw that on a monthly basis reports were completed which looked at the key themes and issues arising out of complaints made about the trust. The trust also followed up all complaints by offering the complainant a home visit as part of the complaint resolution process.

We spoke to a ward manager who told us that they recently received a complaint from a
relative of a patient with dementia. They told us how they used the information to help members of the staff learn from the complaint and share the lessons across the department. This meant patients were supported in making complaints and lessons learned were shared.
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.
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.
(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.