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

Diana Princess of Wales Hospital

Scartho Road, Grimsby, DN33 2BA
Tel: 01472874111

Date of Inspection: 05 December 2013
04 December 2013

As part of our inspection of this hospital carried out on 4 December 2013 and 5 December 2013, we looked at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. This was part of a themed inspection programme that looked at how providers worked together to provide care and at people’s experiences of moving between care homes and hospital. The evidence collected was used to inform the judgements we made in the inspection report. This annex provides a summary of the evidence collected that related to dementia care.
Details about this location

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<th>Registered Provider</th>
<th>Northern Lincolnshire and Goole NHS Foundation Trust</th>
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<td>Overview of the service</td>
<td>Diana Princess of Wales Hospital is an acute hospital, run by Northern Lincolnshire and Goole NHS Foundation Trust. The trust serves the population of North East Lincolnshire and surrounding areas. The hospital has around 430 beds and provides acute, elective and specialist care.</td>
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<td>Type of service</td>
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Summary of this inspection

What people told us and what we found

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.

We spent two days looking at records and speaking with patients, their relatives and staff about the care and treatment provided at this hospital. We visited B6, C5, C6 and accident and emergency wards.

We spoke with 10 patients and 8 relatives about their experiences during their stay at the hospital. Some of the patient’s we spoke with were assisted by their relatives to answer questions they found difficult.

We also spent a period of time observing staff delivering care to patients in one of the bays on ward C6. This method of observation is called the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care and treatment to help us understand the experience of people who could not talk with us.

We found the hospital had made a commitment to the Dementia Action Alliance’s ‘Right Care: creating dementia friendly hospitals initiative. However, we acknowledge that there is a considerable amount of work still to complete. They have a clear action plan which they continue to work towards.

We found the hospital worked closely with outside agencies to ensure patients received the support they needed when they were deemed medically fit and ready for discharge back into the community.
How are the needs of people with dementia assessed?

We looked at five care and treatment records for patients on wards C5, and C6. We found evidence that the records contained a dementia screening tool which was completed within the first 72 hours after admission. This is known as the ‘Six Item Cognitive Impairment Test’ (6CIT) which consists of a number of questions and forms an assessment to determine the patient’s cognitive ability. The staff we spoke with said if the patient scored above 8 on the initial assessment they were referred to the mental health liaison team for further investigation.

One of the ward managers told us that often people presenting with other cognitive problems such as delirium or depression were given additional tests to rule out other symptoms such as urinary or chest infections. In such cases the mental health liaison team undertook further cognitive tests once the infection had cleared, before making decisions to refer to other services. We saw evidence on one of the care records that a patient had three visits from the mental health liaison team.

The records we looked at showed evidence of the medical conditions which had led to the patient being admitted into the acute setting. For example one patient had been admitted following a fall, resulting in a fracture. Another patient who had diabetes was generally unwell.

There was evidence that relatives had been involved in providing information about their relative’s health prior to becoming unwell. This included things like nutrition, mobility and their mental health. We saw records which confirmed the patient had been assessed in all of those areas of care.

How is the care of people with dementia planned?

We found no evidence on the care plans we looked at that demonstrated the patients specific dementia needs were being met. For example there was nothing to confirm they had taken account of their equality and diversity issues or lifestyle choices. The care records focused on their medical needs such as pressure care, pain, falls risk assessments and mobility. The ward manager told us that there was a doctor assigned to the ward who had a special interest in the care and treatment of people living with dementia. Dementia champions were being identified to improve this area on all of the wards we visited.
Are people with dementia involved in making decisions about their care?

We found some of the records we looked at included preferences for ‘Advanced care planning.’ The document confirmed relatives’ involvement in decisions about end of life care. We found completed do not attempt cardio pulmonary resuscitation (DNAR) forms which were signed by the doctor. However one DNAR form was incorrectly completed. We passed the form to the ward manager to deal with.

We observed staff on C6 for a period of time while they were undertaking their observations of patients. Staff included patients in decisions about pain relief and they took account of their wishes.

We spoke with staff on the wards about their understanding of involving patients living with dementia in making decisions. We received mixed responses. One staff member referred to patients as, “Needing more attention”, “Disruptive”, and “Sometimes aggressive”. Another staff member had a much better insight into involvement by talking about offering choice regarding meals and drinks.

Are people with dementia provided with information about their care?

We found most patients we spoke with were satisfied with the information they received about their care. One patient said, “On the ward I felt the staff did listen to me, I was a bit confused, but they were really patient with me. When the doctors had talked to me nurses came back and asked if I understood what he had said, they explained it again to me. They (staff) always talk to my husband so he knows what’s happening.”

We saw evidence on care records where relatives had been contacted to pass on information about care and treatment. We also observed relatives talking to nurses during visiting to obtain up to date information about their relative’s care and treatment.

One relative said, “I was not given sufficient information about my relative’s care which made me very anxious. Then the quality matron came to me and discussed my relative’s symptoms and the reasons for the changes in their health. This put my mind at ease.” The ward manager told us that relatives could make appointments to speak to doctors about the care and treatment of their relative.

How is care delivered to people with dementia?

The quality matron for dementia had recognised that investment in staff training was essential to ensure they delivered appropriate care to people living with dementia. We were told that the training programme was being rolled out to all staff. Some key staff would receive additional training which covered person centred planning, managing behaviours that challenge, and pain relief for patients with dementia. This programme of training had commenced, however the impact was not evident on the wards we visited.

We spoke with the ward managers on C5 and C6 about their understanding of the needs of patients living with dementia. They told us that training was a key ingredient in the delivery of care and treatment to patients. They were aware that all staff were to attend the dementia basic awareness training and they were able to tell us the dates for their training.
We saw the wards had electronic patient information boards. The board used a picture code for many different elements of patient care needs and was easy to use. Staff had access to all the icon/pictures meanings as part of the boards’ process. The picture/icon regarding patient’s confusion and dementia was a silhouette of a head with a question mark in the middle of the head. Staff told us this was how they were able to identify patients who may need more support when gaining consent to care and treatment. One nurse said, “We know that patients with dementia may need more time to give personal care such as bathing and assistance with meals. Some patients with dementia may be less co-operative, which may involve more than one nurse.”

On our first day of this inspection staff were very busy and were less interactive with patients. One of the ward managers told us they were short staffed and that meant care was more rushed. On the second day the wards were much calmer. We found the care was well led by the ward managers and staff seemed more relaxed. We observed staff being compassionate towards patients with dementia and this included taking time to talk to patients about their family, friends and interests.

We spoke with a number of patients about their care. One person said, “When I was in pain they gave me some extra medication which stopped the pain. If I get upset people will stop and talk to me trying to help me understand what’s going on. I don’t know, it’s just so confusing at my time of life. The staff are lovely and patient with me.”

**Is the privacy and dignity of people with dementia respected?**

Throughout the two days spent on wards C5 and C6 we observed patients were treated with respect. Patients’ dignity was maintained throughout and the relatives we spoke with confirmed staff were respectful at all times. One patient said, “They (staff) are nice here but I want to go home, wouldn’t you?” Another patient said, “The nurses always draw the curtains before they do anything to me.”

Relatives we spoke with said, “I would expect that my relative would be treated with respect. That is part of the fundamental principles of being a nurse. From what I have seen this happens.” Another relative said, “Whenever I have visited staff always speak to me and my relative in a proper manner.”

The patients and relatives we spoke with in accident and emergency said they were happy with the way they were treated. One patient said, “When I first came in I was treated with dignity and respect. Doctors explained what they intended to do and after they had found out what was wrong with me what treatment I would be having. They asked me if there was anything I wanted to say or ask. If I didn’t know what they meant so they told me in a different way, very polite they were.”

During our SOFI observations in one of the bays on C6 we noted that curtains were drawn and staff spoke quietly so that their interactions could not be heard by other patients. We observed doctors undertaking a ward round in this bay and found they gave the patient time to respond to their questions. Nursing staff undertaking observations included patients in conversations about family. Nurses informed the patients about what they were doing for example taking their blood pressure and they informed the patient of the results before moving onto the next person. We saw a phlebotomist explaining to a patient that they needed
to take some blood and they ensured the patient was included in the procedures by explaining why they needed to take the bloods.

We spoke with ward staff at all levels and they were clear about the importance of maintaining and respecting patients’ dignity. The ward manager on C6 said all staff received training on dignity and privacy and would expect all staff to work to the hospital’s policies. The ward manager on wards C5 and C6 told us that they reviewed a selection of patient experience surveys which asked patients and relatives to comment on their experience whilst in hospital. This included topics around privacy and dignity. They told us they could use the information to assess if they were maintaining standards.
Cooperating with other providers

How does the provider work with others when providing care to people with dementia?

We found there was good evidence of the hospital staff working closely together with liaison services to ensure when patients were ready to leave acute services they had the support they needed.

We spoke with the ‘Mental Health Liaison Team’ who worked for a Health and Social Care Community Interest Company which provided health and care services to the people of North East Lincolnshire. They received referrals from ward staff following cognitive assessments which required further investigation. We saw evidence on the care records of the liaison teams visiting patients and speaking to their relatives. They worked closely with the ‘Home Team’ which ensured the safe discharge of people back home or to appropriate care settings.

We saw other staff within the hospital were also involved in the assessment of a patient living with dementia, when they were deemed medically fit. For example we saw physiotherapists and occupational therapists were involved in planning the discharge of one patient we had case tracked. We spoke with the patient’s relative and they told us they had been kept informed about the things that needed to be in place before their relative was discharged.

We also spoke with the quality matron who was in charge of the monitoring and reducing the risk of falls within the hospital. She had responsibility for referring people to the community falls clinic. This took place if the patient had been identified as a fall risk or had been admitted to hospital following a fall. This meant people living with dementia received additional support after discharge to prevent re-admissions into acute settings.

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

We found the mental health liaison team provided links to assisting people living with dementia on their onward journey. They ensured referrals were made to the community teams for support on discharge. They also made referrals to the care home community support teams, and to mental health providers for the purpose of further assessments.
Assessing and monitoring the quality of service provision

How is the quality of dementia care monitored?

We spoke with the ward managers about how they managed concerns and complaints. They told us they ensured they were visible and available during visiting times so that relatives and carers could speak to them. They told us this seemed to prevent minor concerns from escalating into complaints.

The quality matron for dementia told us they were working with voluntary sector groups to improve patients' experiences. They told us ward C6 had been selected to be part of a pilot for improvements to the environment, including colour themes, signage, and dignity rooms. This was still in the planning stage in conjunction with the works department.

They also used of a “memory pod” in the hospital’s restaurant during dementia awareness week. This had been successful in raising awareness with staff.

There was a “quality improvement project “which has been compiled with medical students from Hull University. The project was carer focused. We were told the project was at draft stage and was designed to assist carers with sign-posting and gaining support.

The quality matron for dementia told us the dementia delivery plan was to be “Rolled out” in January 2014. The plan covered many aspects of care delivery for the person living with dementia who had been admitted to hospital. For example addressing issues of admission to hospital and delayed discharges. It also looked at falls information. We spoke to the falls quality matron who told us they had introduced new measures to help reduce the risk of falls to patients living with dementia. They had found there had been a significant reduction in falls following a review of equipment. For example ultra-low level beds, sensor pads and a review of safety sides on beds.

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

We found risks assessments had been completed on the care records we looked at. One patient’s care record showed evidence that they had been referred to the physiotherapist for a walking frame to ensure they were safe while moving around the ward. We also found evidence that pressure care and hydration and nutrition had also been risk assessed.

We spoke with the ward managers about keeping patients safe. We were shown accident and incident books which were used to record patient accidents. The ward managers said the records were analysed to ensure lessons were learned and acted on to prevent further accidents.
Our observations on the wards we visited confirmed that staff were aware of potential trips and slips hazards. Staff were careful when using equipment to ensure the environment was safe for patients with dementia to move around.

**Are the views of people with dementia taken into account?**

We found it difficult to confirm if the views of patients living with dementia were taken into account. Care plans and records that we looked at were inconclusive. However the introduction of the ‘My life whilst in hospital’ document may assist in ensuring patients’ views and beliefs are taken into account during their stay in hospital. The document gave patients and their relatives the opportunity to write down their wishes with regard to their care. It also gave a pen picture of the patient’s life history, likes and dislikes. The dementia lead told us that this document should be widely available to care homes and nursing homes and it should accompany the person when admitted to an acute setting. None of the care and treatment records that we looked at had the document for staff to use.

We asked a junior doctor if they had seen the information during their time in accident and emergency, but they had not seen it. One nurse said that they had seen it but it sometimes got lost during moves to various wards. Other staff said sometimes patients from care and nursing homes were admitted without any support making it difficult to determine the patient’s cognitive ability to give their views on care and treatment. In those instances staff told us they telephoned the care home or relatives to gain essential information.