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

## University Hospitals Bristol Main Site

Bristol Royal Infirmary, Upper Maudlin Street, Bristol, BS2 8HW

Date of Inspection: 22 January 2014  
Date of Publication: March 2014

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

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<tr>
<td>Cooperating with other providers</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓ Met this standard</td>
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### Details about this location

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<th>University Hospitals Bristol NHS Foundation Trust</th>
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<td>'University Hospitals Bristol Main Site' is a location of the University Hospitals Bristol NHS Foundation Trust. A range of acute and specialist services are provided from the location. The location’s hospitals include the Bristol Royal Infirmary, the Bristol Royal Hospital for Children, St Michael's Hospital, the Bristol Eye Hospital and the University of Bristol Dental Hospital.</td>
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Surgical procedures  
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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 22 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and received feedback from people using comment cards. We 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 looked at the care for people with dementia in the Bristol Royal Infirmary. This is an acute hospital which forms part of the Trust's location called 'University Hospitals Bristol Main Site'. We spent time in the hospital's Medical Assessment Unit (MAU), the Accident and Emergency Department (A & E) and in two wards for older people. Our findings were limited to the scope of the inspection programme and were not indicative of standards in other areas of the hospital and the location as a whole.

Patients and relatives we met with were mostly positive when talking about the staff. They commented, for example, that staff were very "very attentive" and "look after us very well". We observed examples of good practice, such as when staff interacted well with people and were able to establish a good rapport. However we also saw occasions when staff missed opportunities to engage with the individual or did so in an uninterested manner. Where procedures and guidance had been introduced to support staff, these were not being applied consistently across the hospital.

The Trust had identified a number of areas where improvements were needed in the care of people with dementia. Some key actions had been taken, such as training for staff about dementia and developing systems for ensuring that there was good communication
with other providers. However further developments were needed in order to ensure that people with dementia experienced a well planned and person centred approach to their care.

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 29 March 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

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<th>Care and welfare of people who use services</th>
<th>Action needed</th>
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<tr>
<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 not meeting this standard.

The Trust was taking steps to improve the care provided to people with dementia. However there were shortcomings in the arrangements being made for assessing the needs of people with dementia and in the planning of their care. There was a risk that people with dementia would not receive care that was safe and of good quality. Interactions between staff and patients with dementia were mostly positive although there were occasions when staff did not engage well with people.

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

We spent time in the Medical Assessment Unit (MAU), the Accident and Emergency Department (A & E) and in two wards for older people. At the time of our visit, these wards were being brought together and designated as an Elderly Admissions Unit (EAU). We spoke individually with nine staff who in working in these areas and they told us about the care they provided to people with dementia. We talked with other staff who had specialist roles within the hospital. We met with patients and with relatives, and observed how staff supported people with dementia. The Trust provided us with information about the care of people with dementia and we looked at examples of the care records. We carried out ‘pathway tracking’, which is when we look at an individual's route through the service and their experience of the care being provided.

How are the needs of people with dementia assessed?

Information about people's conditions at the time of their admission was obtained from a variety of sources. In the A & E department, for example, staff said that ambulance crews provided them with important details about people's needs. We were told that this could include information about whether the person had a diagnosis of dementia. Staff on the MAU said that people admitted from care homes usually came with information about their needs. GP referral letters and feedback from relatives were also mentioned as sources of information.

This information helped to ensure that people with a diagnosis of dementia were identified
and their needs could be assessed upon admission. However, staff said that the quality of information varied, and commented that the detail received from care homes ranged from "brilliant" to "very poor". We spoke with staff who recognised the need to ensure that gaps in information were followed up as much as possible.

Staff told us about training they had received which had increased their understanding of dementia. Information provided by the Trust showed that good progress had been made in increasing the number of staff who had received some form of training in dementia. We were told, for example, that 93% of staff who had contact with adults had attended dementia awareness training. This meant that staff were aware of how the condition affected people and the importance of assessing people’s individual needs.

However, we found that the arrangements made for assessing the needs of people with dementia lacked a consistent and personal approach. This was seen in our pathway tracking of four patients and in the records we saw for seven other people with dementia. Information was recorded which reflected an assessment of their medical and nursing needs, although a specific dementia screening assessment had not been undertaken. The Trust told us that their own audits of standards in dementia care had identified that improvements were needed in the screening of patients for a possible dementia.

Where a diagnosis of dementia had been confirmed, there were shortcomings in the documentation relating to the person’s needs and individual circumstances. For example, the Trust had told us about a booklet called 'This is me' which was used to inform staff about people’s needs, preferences, likes, dislikes and interests. Staff had spoken positively about the booklet and its purpose although we found that it was not being used consistently. In nine of the eleven records we looked at relating to people with dementia, we saw that the 'This is me' booklet had not been completed. This meant that staff did not have the information they needed to ensure that care was provided in a person centred way.

Staff we spoke with were aware of the importance of assessing pain in people with dementia who may not be able to express what they are feeling. Staff were aware of a tool that could be used to assess the level of pain in people with dementia, but also acknowledged that this was not being used consistently. We saw this was the case when we looked at people's care records; pain assessment forms were available but these had not been completed. One staff member commented "we don't ask people on the medical wards enough about their pain". Without a suitable assessment, there was a risk that people's pain would not be recognised and responded to adequately.

How is the care of people with dementia planned?

Care plans were in place which reflected a range of medical and healthcare needs. Through 'pathway tracking' we saw that plans had been written in relation to areas such as mobility, pressure area care and infections. However, there was no specific care plan for dementia and people’s records did not show that a dementia pathway was being followed. This meant that staff did not have the opportunity to anticipate symptoms, and to prevent them or to reduce their impact. We saw there was a lack of person centred planning because the fundamental document 'This is me' had not been completed in the majority of records we looked at.

Medical and nursing records included references to people being 'aggressive', 'agitated' or 'challenging'. However, we found that care planning did not reflect the support that people
needed with their condition of dementia. In one person’s record, for example, we read that they were 'very aggressive, distressed and confused'. There was no plan in place to ensure that staff had good knowledge about this person’s condition and how it affected them. Where there was guidance for staff about responding to people’s behaviour, we found that this was not being consistently followed (refer to "How is care delivered to people with dementia?"). Staff we spoke with on one ward said that if "physically aggressive" they could call security to come and help. We were told that this was a last resort because it could "aggravate the situation". In information we received from the Trust they acknowledged that 'the management of behaviours that challenge us' was an area for improvement due to the current lack of training and documentation.

The Trust told us about initiatives that had been introduced to help ensure that care was provided in a way which met the needs of people with dementia. This included use of the 'Forget me not' system, which provided a discreet way of identifying patients who have dementia and may need additional reassurance or assistance from staff. Staff we spoke with were knowledgeable and very positive about the system although we found that it was not being used consistently with people with dementia. This meant that there was risk that a person would not receive the additional support that they needed because of their dementia.

The Trust informed us of the arrangements being made for supporting people with hydration and increasing fluid intake for those people at risk. These included the use of red drinking glasses, which would be more visible to people, and red lidded jugs to identify those patients who needed encouragement or assistance to drink. When we visited the MAU and wards we found that the arrangements for using these items varied. We were told that in one area the red lidded jugs had been ordered and staff were waiting for these to arrive. We also heard that on one ward the red glasses were being used for everyone so that people with dementia "did not stand out".

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

For the most part, we found that staff sought to involve people with dementia in making decisions and choices about their care. We observed a number of occasions when staff asked people about their care and their individual preferences. These included occasions when people were asked how they wanted to spend their time. Staff, for example, were heard to say "would you like to have a lie down on your bed now?" and "is there anything else I can get for you". One patient commented "the nurses have been good and helped me with anything I wanted".

At lunchtime, we observed staff on one ward asking people about their meals and individual preferences. We heard, for example, "you wanted an omelette today, would you like some mashed potatoes and vegetables with it" and "how are you getting on with it, is it nice .... are you managing to chew it alright .... would you like something else". Another person with sandwiches was asked "would you like me to cut off the crusts for you". We spoke with staff who were aware that people may be able to make decisions about some aspects of their lives, but not others. We saw some information about mental capacity in people’s records. In one person’s record we read that there was a concern that the person was declining to eat and drink. It was recorded that they did not have capacity to make an informed decision about their refusal to eat and drink. This showed that people’s capacity was being assessed individually in relation to specific decisions about
their care and treatment. Staff told us that a plan had been discussed for how the refusal should be responded to. However, a ‘best interest’ meeting had not yet taken place and there was a lack of documentation about the process being followed. The records did not show that action was being taken in a timely way.

Are people with dementia provided with information about their care?

Staff we spoke with were aware of the need to take time to explain to people the care and support that was being offered. Staff were heard talking to people about their care and asking questions such as “how are you feeling”. We heard doctors explaining who they were, giving clear information about treatment and checking if patients were happy and had any questions. A nurse was observed talking to one patient; they got down to the patient’s level and explained what she was intending to do. The patient smiled and nodded and once the nurse had confirmed that the patient was in agreement, they drew the curtains inside the bay.

We were shown laminated cards with information in the form of pictures and symbols. Staff said that information in a visual form helped people to make their wishes and needs known. Information in people’s records such as care plans was not presented in a user friendly way. This meant that they would be more dependent on staff and visitors to provide them with the information they needed about their care.

How is care delivered to people with dementia?

We received information from the Trust about a range of developments in relation to the care of people with dementia. We were told, for example, about the recruitment of dementia champions and work being undertaken to create a more dementia friendly environment. There had also been a programme of training to support staff in understanding how best to care for people with dementia. These arrangements helped to ensure that there was a better awareness of the needs of people with dementia.

Staff we spoke to recognised the benefits of these developments, but we also heard about obstacles to achieving good outcomes for people. No wards were specifically designated for the care of people with dementia and the current configuration of the wards meant that people with dementia were cared for alongside people who had no such needs. Comments from staff highlighted the challenge they faced in ensuring that the needs of people with dementia were identified and responded to effectively. We were told that ward closures were not uncommon and there were pressures relating to staffing and bed capacity. One staff member, for example, commented "they try and rush people through, sometimes not enough time is given. Patients are moved at night, everyone is in a rush and putting pressure on people".

Staff in the different areas we visited told us that on occasions patients were assessed for receiving one to one support. We heard that the response to this was varied. In one area we were told that requests for additional one to one help were "usually granted". In another area however we heard that it was more difficult to provide this extra staffing.

Arrangements were in place for reviewing care plans and monitoring people’s day to day needs. One staff member, for example, commented "care plans are reviewed every seven days, nutrition charts every three days. Everyone who has dementia is on a nutrition chart". We were also told "we review the care plan every Sunday or sooner if there has
been deterioration. We write in the care log in front of the file about what care we have given.

The food and fluid charts we saw were up to date, with one exception which we brought to the attention of the ward sister. Recording in relation to people's dementia tended to describe behaviour rather than provide an evaluation of the circumstances in which it had arisen. This meant that there was a lack of good information when people's care was being reviewed.

The feedback we received and our observations of support highlighted some variation in the quality of care that people received. Patients and relatives were mostly positive in their comments about the staff and how they went about their work. Their comments, for example included "I'm comfortable here, they look after us well" and "the nurses have been good and helped me with anything I wanted". One person described the staff as "very patient with people and very understanding". However, they told us that their experience of care was adversely affected by the attitude shown by one staff member in particular. We brought this to the attention of the ward sister.

Our observations of care showed that staff were busy and combined responding to requests from patients with the carrying out of their routine checks. We saw some very positive interactions, such as when staff adopted a friendly approach and used the care task as a time to engage in conversation with the patient. However there were also missed opportunities, for example when we saw staff regularly entering one person's bay without acknowledging their presence.

When visiting another area, we were aware of one person who had been shouting and calling out throughout our time there. We discussed this with the staff present. Although some 'one to one' support had been arranged, this was not being provided in a way which was consistent with the guidance that had been produced about the person's needs. We saw that there was lack of empathy and personal interaction, and person providing the support was heard to say "you should not shout like that".

Is the privacy and dignity of people with dementia respected?

Staff were mostly observed to be supporting people in ways which respected their privacy and respect. Curtains were routinely drawn around beds so that care was provided in privacy. We also saw that staff supported people with maintaining their dignity, for example by checking that they were suitably dressed when in bed and when walking around the ward. On one occasion, after being hoisted into their side chair, a person was asked if they wanted a sheet to cover their legs, which they agreed to. Our observations showed that staff were aware of the need to be aware of people's dignity and how this could be compromised without their support. Staff in the A & E department told us that although it could be a challenge, maintaining the patient's privacy and dignity was always a priority when treatment was being provided.

Patients on the wards were being cared for in 'same sex' accommodation. We saw that female and male areas were identified by the use of pink and blue door frames. The colours did not particularly stand out from the general décor although the intention was to help patients to identify their beds.

Our observations of care and support included use of the SOFI (Short Observational Framework for Inspection) tool. The SOFI tool helps us to closely observe and record the
support that they receive and how this impacts on their wellbeing. This is particularly used in situations when people are not able to pass on their own views directly.

In one area we had observed staff engaging well with patients during the lunch meal and asking about their individual needs. We had also seen staff positioning themselves well in relation to the person and maintaining good eye contact. We undertook the SOFI in another area and the quality of engagement was more varied when people received support with their meals. One staff member had initially engaged well with the patient at their level, but later appeared distracted and then provided support with eating while standing over the person. Another staff member did not explain to the person they were supporting what they were doing and adopted a similar standing position. This was a task centred approach which lacked any personal interaction.
Cooperating with other providers

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

Our judgement

The provider was meeting this standard.

The Trust had procedures in place for the planning of care and the sharing of information when people moved between services. Steps were being taken to increase the effectiveness of the arrangements so that people with dementia benefited from a more coordinated approach to their care.

Reasons for our judgement

We spoke with staff in the Medical Assessment Unit (MAU), the Accident and Emergency Department (A & E) and in two wards for older people. Staff told us how they worked with others when providing care to people with dementia. We heard about the arrangements made with other providers to meet the needs of people with dementia. The Trust provided us with information about discharge procedures and how information was shared between services.

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

In the different areas of the hospital we visited we were told about the arrangements made for working with other departments and providers. Overall, we found that there were well some established procedures in place, with work being undertaken to develop these and to improve communication and the sharing of information.

Staff in the A & E department told us that they had seen an improvement in communication with ambulance crews. They said that better information was being passed on to them by the crews. This included statements about people's wishes and information relating to their needs when admitted to the hospital from a care home. In the MAU and in the wards we heard that information coming from care home varied greatly. We were told that phone calls were often needed to ensure that staff had the information they required, particularly when people were not able to express their own needs.

As reported under ‘Care and welfare of people who use services’, the records in relation to assessments and care plans did not provide evidence of good, person centred information to enable smooth transitions of care. This would also have an impact on how well information was transferred when people moved within the hospital. We were told by the Trust that work was being undertaken to reduce inter-ward moves of older people. A project group was also looking at ways of reducing the admission of older people, particularly those with dementia.
Information we received from the Trust included details of other projects and pilot schemes that were being undertaken in conjunction with other agencies. A number of these had the aim of promoting better communication between providers and a more coordinated approach to people's care. We saw, for example, that new documentation had been produced to use when people moved between hospital and care home. This meant that information would be shared in a more timely and consistent way.

Attention had also been given to the discharge procedures. There had been developments in how discharges were managed and who co-ordinated the arrangements. We received good feedback about the changes that had been made and the work undertaken by a discharge liaison team. A nurse we spoke with commented that the team were good at contacting other agencies. We were told that the involvement of the team meant that nurses' time was "freed up" and they could spend their time more efficiently.

Staff told us about their role in the discharge arrangements. Their feedback about the arrangements was positive. One staff member said that a "general assessment" was undertaken before a person left their care. We were told that, on discharge, "all information is given to the care home". Comment was also made that "we would seek consent" and if the patient had capacity they were involved in the discharge arrangements.

We met with one relative who specifically mentioned the arrangements being made for the discharge of their family member. They told us that the nurses had been "very attentive" and "were working hard to complete a fast track discharge ... we have all been very involved with the plans and discussions and they have liaised with other agencies ... things that we haven't even thought of. If it all works it will be great".

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

People with dementia were assisted with obtaining a range of health and social care support from within the hospital. Staff told us about the services that were available and in people's care records we read about their contact with different healthcare professionals.

In each area we visited staff described the arrangements by which patients were seen by doctors and other health care professionals on a regular basis. We were told about meetings to discuss patients' needs. One staff member, for example, told us they had "a meeting every morning at 9am, a multidisciplinary meeting which everyone comes to - physiotherapist, occupational therapist, nurses, doctors, and pharmacist".

We were told about other specialist services that were available through the hospital. These included referrals to a psychiatric liaison team. The Trust was not able to refer patients directly to memory services but we were told that referrals were made through the patient's GP. A nurse told us "if any problems are identified with nutrition we will refer to dietician and offer snacks and sandwiches".

A member of staff was in the role of 'Falls Assistant', which meant staff made a referral to them if there was a risk that a patient might fall. It was their job to reduce the risk and we observed them engaging very positively with a person with dementia and building a good rapport. They told us that they worked as part of a team and had weekly meetings with the lead nurse for dementia. This helped to ensure that there was a coordinated approach to supporting people with dementia.
Through pathway tracking we noted that support from a social worker had been obtained and there had also been contact with professionals who had a role in relation to safeguarding adults.
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 quality of dementia care was being assessed and shortcomings in the service were recognised. Overall, the Trust was taking action and had plans in place to improve the service that people with dementia experienced.

Reasons for our judgement

We looked at how risks to people with dementia were managed and how their safety was promoted. Staff told us how the service was monitored and we heard about a number of new initiatives. We received information from the Trust about audits and the plans that were in place to improve the service for people with dementia.

How is the quality of dementia care monitored?

Information we received as part of this inspection showed how the Trust was working towards achieving the South West Hospital Standards in Dementia Care. The standards were designed to promote improvements in hospital care for people with dementia. The Trust had mapped these standards to the NICE (National Institute for Health and Care Excellence) Quality Standards for dementia care and undertaken a baseline assessment.

The Trust had undertaken a number of developments in relation to meeting these standards. These included training and other activities to increase staff awareness of dementia. Current developments included changes to care documentation and the creation of personalised care plans. We were told that these developments were in order to ensure that care was delivered in a way which met people's individual needs. As reported under 'Care and welfare of people who used services', these were areas where we found shortcomings and where improvements were needed.

The Trust had identified further areas for improvement and told us that an annual audit of dementia care within the hospital was undertaken. Information provided by the Trust included details of their involvement in national and trust led audits since 2012. This showed that the quality of the service was being checked and shortcomings identified.

The audits included conclusions and recommendations about the standards achieved. Following an audit in November 2012, for example, it was concluded that patients with cognitive impairment do not consistently receive 'optimal assessment and care' as set out
by national and regional guidelines. From the audit undertaken at this time, it was seen that a range of improvements and developments were needed in order to achieve the expected standards.

Audits referred to the strategies that would be needed to improve the care received by patients with dementia. The feedback we received showed that progress had been in some key areas. This had included the recruitment of 135 dementia champions from within the staff team. A clinical lead for dementia and a lead nurse for dementia had been appointed to promote good practice and to act as an 'in reach' team resource. These developments helped to ensure that the arrangements being made within the hospital were consistent with good dementia care.

Plans had been produced with actions for how improvements would be made, as identified at the last clinical audit in November 2012. Timescales were identified for the completion of actions, with a latest completion date of March 2014. An action relating to the creation of a care pathway for older people with dementia had not yet been completed. The provider may wish to note that we found that progress in some areas was limited and the rate of improvement was not being closely monitored. We were told that the next full audit was due to take place in February 2014. We saw that a data collection tool had been developed to use in this audit. The tool covered a range of areas and included questions, for example, about the screening of people for dementia and use of the 'This is me' booklet. This meant that the Trust would have the information needed in order to assess the progress that was being made.

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

We spoke with staff who told us how risks to people with dementia were being managed. In the Accident and Emergency department, for example, a daily safety briefing took place. This provided the opportunity for staff to be updated on any concerns and risks to people. We also saw that daily notes were being audited to highlight any issues which needed to be brought to the attention of staff.

Staff we spoke with in the A & E department were aware of the vulnerability of people with dementia. They talked about their role in relation to safeguarding adults and the reporting of allegations of abuse. Staff recognised that this was particularly important as the A & E department would be where a number of people with dementia were first seen within the hospital

In other areas, we heard about the arrangements in place for monitoring risk, including the use of a monthly 'safety thermometer'. This was a means of measuring harm, for example from pressure ulcers, and the proportion of patients who were 'harm free' during the month. The data collected each month helped to identify areas for improvement. Staff told us that incident forms were being completed, for example, when risks had been identified and there were safety issues to be highlighted.

Some adaptations were being made within the environment to take account of the needs of people with dementia and to promote their wellbeing. In the A & E department, for example, staff said that a quieter area within the department would be used whenever possible. We were told that the end bays in a row of examination bays would be used for people with dementia. Staff said that these bays were next to the toilets, which helped with orientation. In a ward area, colour coding had been used around the bays to help people identify where there bed was.
We saw that some areas were available to people for social activities. The Trust told us about a 'reminiscence pod' that was available to people on one ward. This was designed to be a facility within the ward that would encourage conversation and reassure people with dementia. In another ward we saw a small area that was designated as a 'social area' for patients. This was situated in a busy area near the entrance to the ward; a location which was not ideal for patients with dementia.

One person we spoke with commented "the only problem is the noise sometimes" when talking about their ward. Overall we found that environmental enhancements in relation to the needs of people with dementia were limited. In information received from the Trust they had identified this as an area for further consideration and development.

Are the views of people with dementia taken into account?

The Trust had a range of procedures in place for obtaining the views of patients. These included the use of surveys and comment cards. We were shown a new leaflet that had been produced, in which people with dementia, or someone in a supportive role, were invited to pass on their views. The leaflet also provided information about forthcoming events relating to the needs of people with dementia and those of their carers.

Information received from the Trust included examples of actions that had been taken in response to recent feedback and how these had been of benefit to people with dementia. They included improving the information on the wards about dementia and we saw evidence of this during the inspection. We were told that there had been good feedback about the hospital's befriending scheme and the carer liaison support service, and that these were being further developed. A staff member we spoke with felt that the befriending scheme was a good service for people with dementia.

The Trust told us about actions that had been taken following observations and peer reviews undertaken within clinical areas. These included ensuring that the principles which underpin a positive therapeutic environment for people with dementia were incorporated into refurbishment programmes. We were told that attention had also been given to visiting times, which had been extended to provide greater flexibility for patients and their relatives.

We received positive feedback about the work undertaken by the Trust's lead nurse for dementia. The Trust told us that consideration was being given to the creation of dementia clinical nurse specialist post to provide a clinical service that would complement the work undertaken by the lead nurse.

As part of this inspection we left comment cards for patients, staff and visitors to complete during the week following our visit. Two cards were completed. One person commented that there was a now a greater awareness of dementia, but "still a long way to go" and "implementation of initiatives patchy". The second person commented that the hospital was “OK” and that "people talk nicely".
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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Care for people with dementia was not always planned and delivered in ways which met their individual needs and ensured their welfare and safety.</td>
</tr>
</tbody>
</table>

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 29 March 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.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ <strong>Met this standard</strong></td>
<td>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.</td>
</tr>
<tr>
<td>✗ <strong>Action needed</strong></td>
<td>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.</td>
</tr>
<tr>
<td>✗ <strong>Enforcement action taken</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Outcome</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Staffing</td>
<td>13</td>
<td>22</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Complaints</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Records</td>
<td>21</td>
<td>20</td>
</tr>
</tbody>
</table>

**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.