

Dignity and nutrition for older people

Review of compliance

**South Tyneside NHS Foundation Trust
South Tyneside District Hospital**

Region:	North East
Location address:	Harton Lane South Shields Tyne and Wear NE34 0PL
Type of service:	Acute Service
Publication date:	July 2011
Overview of the service:	<p>South Tyneside NHS Foundation Trust was registered with no conditions in April 2010. It employs approximately 3000 staff and provides community and acute health care services to approximately 180,000 people in South Tyneside and the surrounding areas.</p> <p>The main acute services are provided at South</p>

	<p>Tyneside District Hospital site where the following regulated activities: family planning; maternity and midwifery services; nursing care; surgical procedures; termination of pregnancies; diagnostic and screening procedures and treatment of disease, disorder or injury are provided.</p>
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Summary of our findings for the essential standards of quality and safety

What we found overall

We found that South Tyneside District Hospital was not meeting one of the essential standards we reviewed. Improvements were needed.

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

Why we carried out this review

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

How we carried out this review

We reviewed all the information we held about this provider, carried out visits on two wards on 18 April 2011, observed how people were being cared for, talked with eight people who use services, talked with six staff, checked the provider's records, and looked at records of people who use services.

Our inspection team was joined by a practising, experienced nurse and an 'expert by experience' – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

What people told us

Patients told us that they were satisfied with the care and treatment they received. They said that most staff had treated them with courtesy and respect and that their privacy and dignity had been protected. They said they were given information and had been involved in decisions about their care.

However, some described instances where they felt staff had been abrupt in their manner and lacking in respect.

Patients told us they felt their nutritional needs and dietary preferences were well met. They gave mainly positive feedback about the quality, range and availability of food.

What we found about the standards we reviewed and how well South Tyneside District Hospital was meeting them

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

We found that the majority of patients were supported to make choices and had some opportunities to influence service delivery, but people were not consistently treated with respect and their dignity was compromised.

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

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

We found that patients were offered a healthy balanced diet and their nutritional needs were assessed and understood. However practices and support needed to be further developed to improve the mealtime experience and recording of food intake.

- Overall, we found that South Tyneside District Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality
and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
We observed that the majority of staff anticipated and responded to patients' needs and requests and delivered timely support. They offered choices to patients before providing assistance with personal care, explained the reasons and gave them time to make decisions.

The majority of staff were respectful and polite to patients. Staff mainly referred to patients by their first names and several staff called patients 'darling'. We heard one staff nurse asking someone how they wanted to be addressed.

We saw instances when staff reassured patients and acknowledged their feelings and anxieties. For example a staff nurse who sensitively reassured a patient who was worried about her treatment.

Patients told us that the majority of staff were always patient and sought their permission before providing them with care. However, each of the six people who we talked to told us that occasionally some staff had been abrupt in their manner

and not respectful. One patient said that 95% of the staff were very good but 5% did not speak to patients with respect. This person added that the doctors were all very good but the nurses did not always make it clear what they were going to do. A patient on the stroke unit described an incident where one nurse had been 'very abrupt' and said that this matter had been quickly resolved when they had complained.

We saw that one health care assistant on the elderly care ward was verbally sharp with an elderly patient stating, "You should pull the red cord and then we would know when you are finished". When we spoke with this care worker they told us they had received training in privacy and dignity but could not remember much about it. They told us that they asked patients what their wishes were and then did their best. This person added 'we just stick to our routines'.

Our observations of care also showed that the dignity of some patients was compromised. This included a patient who was in bed on the elderly care unit. This person was in a single room and had their back to the door. We saw that the patient constantly called out for help and rattled the bedrail as staff passed by and we noted that twenty-five minutes passed before this patient received attention. When we spoke with the patient we observed that their fingernails were ragged and dirty.

We observed a patient who was wheeled across a corridor to and from the toilet on the elderly care unit. The patient had bare legs and feet which were exposed and their feet were in direct contact with the rubber foot rests.

One patient's abdominal area was uncovered throughout the visiting period on the stroke unit whilst they were asleep in their chair.

A health care assistant on the elderly care unit produced a comb from her own pocket and proceeded to comb a female patient's hair without asking or saying what she was about to do.

A specialist nurse who approached a patient to take her to the bathroom had no name badge. She did not introduce herself and the patient told us she did not know who the nurse was or what she was going to do.

We also observed that staff gave good eye to eye contact and made regular hand contact to which patients responded well. Staff attempted to communicate discreetly with individuals when assisting them in communal areas.

We saw some lengthy periods in between care delivery to frail and bed bound patients on the elderly care unit. Some patients felt that occasionally staff were slow to respond. One patient explained this was due to 'staff shortages'.

We met with some people who were slightly confused and found that they appeared content and relaxed. One patient continually wandered to the nurses' station. She was taken back to her room by various staff members who treated her with respect and kindness.

Patients on the stroke unit spoke highly of the nursing and medical staff. We saw that patients were asked what they would like to drink and that the ward hostess had good knowledge of what each patient preferred. Staff took note of patients' requests and most patients were responded to promptly. Staff told us they were instructed to promote patients' independence and we saw that this was carried out in practice.

Patients told us that they had been asked for feedback and that staff had listened to any suggestions.

We were able to speak with one of the dietitians who referred to the use of feedback questionnaires and the involvement of patients in choice and preferences at mealtimes.

Everyone had access to suitable lockers and cupboards to store their belongings. The majority of patients had call bells within easy reach of their bed and bed side chairs. Some immobile patients on the stroke unit were unable to access their bed tables which meant they could not access their drinks and personal belongings.

Privacy curtains were used appropriately and the volume and tone of staff voices was appropriate. Patients were either in single sex bays or in their own bedrooms. Patients on both wards had suitable access to toileting and bathing facilities and staff on one ward told us there were plans for improved provision of en-suite facilities.

Some bays had accessible communal toilet facilities and others had toilets and bathing facilities in close proximity. Communal bathing and toilet areas were identified as male or female with suitable pictures and signage to assist people who may be confused and disorientated. Staff used the vacant/engaged signs when assisting patients to the toilets and were prompt to offer support to people who wished to mobilise independently.

Both wards had spacious, well equipped and pleasant communal dining areas. However the opportunity for people to mix, to move and experience the stimulus of an alternative location was not offered on either ward. Staff told us that patients preferred to stay within their bays or single rooms. They could not say how this had been assessed with patients who were confused and disorientated.

Other evidence

We referred to our Quality Risk Profile where we hold all our information about the hospital. This demonstrated that we had insufficient current information to show whether this standard was being met.

However information from the 2009 adult inpatient survey had included feedback about nurses and doctors talking in front of patients. Some patients had reported that they had not been treated with respect and dignity while they were in the hospital. There had also been some negative comments relating to staff attitude and bad manners.

During this review the hospital provided us with their Action Plan 2010/2011 in response to the 2009 inpatient survey. We saw updates in August 2010 which stated that patients and relatives had reported that they were well informed. Also that the numbers of complaints about doctors and nurses attitudes and lack of information had reduced.

We were informed that at least sixteen staff of varying designations had attended a Privacy and Dignity Champions event where the actions to take forward had included:

- Addition of the Look at Me DVD into the new trust induction from Jan 2011

- Development of clear expectations for staff when transferring patients from one ward/dept to another

- Development of a system for using preferred names for patients

- Increasing the amount of dementia care training

- Ward and department teams were to discuss good and bad staff attitudes and how any issues were to be addressed.

We were provided with a privacy and dignity lesson plan and a privacy and dignity care plan template.

We looked at information on the NHS choices website which contained mixed but mainly positive comments and feedback from patients and their relatives.

We saw that details about the hospital and associated services were provided on the wards in the form of leaflets and information on notice boards.

We were informed that the guide to the hospital's services and facilities was being updated to include information specific to the different wards. A section of this guide focused on how patients could give their views. One of the methods described the completion of a 'viewpoint card'. We also saw that the 'Trust welcome and information pack' referred to the use of these viewpoint cards. However we found that these were unavailable and the staff we spoke with were not aware of their existence. We also found that complaints leaflets were not readily accessible and took time to be located.

Senior staff on the elderly care unit told us that the guide to services would be updated once the function of the ward was clarified. They said this was currently under review due to the level of older patients with mental frailty and longer term needs who were now being accommodated. They also recognised there were training implications for staff to equip them with the necessary skills in caring for people with dementia.

Information about privacy and dignity was displayed. This included the identified 'dignity champion' for the ward, philosophy of care and information on same sex and mixed sex accommodation. Staff said they asked patients about their preferences and usual routines and involved relatives to act in the best interests of people who were unable to express their opinions. There had also been some involvement of advocacy services and Independent Mental Capacity Advocates to help patients who lacked capacity with making important decisions.

Senior staff said they lead by example and had introduced new ways of working to

minimise institutionalised practices and improve communication. An example of this was a more proactive approach to keeping relatives informed about patients' health and welfare at visiting times, and developing the recording system to verify this communication. We were told on one ward we visited that the staff team was looking towards improving information to address the issue of patients with insufficient clothing and toiletries.

Staff told us that they had enough time to give patients the care they needed, though realised there were times when patients might have to wait for assistance. Male staff told us they were given clear information about patients who did not want help with personal care from males.

The patients' records we examined contained areas to document preferred gender of carer and comments on privacy and dignity. We saw that most of these sections to identify individual's preferences were not completed. There was no evidence within the records that assessment of mental capacity was carried out to establish the patient's ability to give consent and make particular decisions about their care and treatment.

Records for patients on the stroke unit showed a co-ordinated approach by a range of medical professionals with emphasis on treating the person's physical condition. The documentation was designed to give a holistic overview with details of the patient's emotional state, communication, coping and mood. However, staff had not completed these sections that would have showed evidence of assessment involving the patient and acknowledged the psychological effects of their illness.

Staff described systems for gaining feedback from patients and their relatives as being mainly informal. Some were aware of the Patient Advice and Liaison Service (PALS) and of internal surveys being carried out, but did not know about the collated findings of peoples' experiences of care. The staff we spoke with said they had not received or could not recall training or guidance relating to privacy and dignity and patient involvement.

Our judgement

We found that the majority of patients were supported to make choices and had some opportunities to influence service delivery, but people were not consistently treated with respect and their dignity was compromised.

Outcome 5: Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:

- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are minor concerns with outcome 5 – Meeting nutritional needs.

Our findings

What people who use the service experienced and told us

Our observations at lunchtime showed that patients were served their meals at the bedside. Dining areas within day and multifunctional rooms were not used.

The elderly care unit was quiet and peaceful throughout our visit. Prior to the lunchtime meal patients were issued with a hand wipe and apron following instruction from the ward manager. We saw that some patients were offered assistance to clean their hands before the meal but none were given the opportunity afterwards. On the stroke unit the nurses offered assistance with hand washing before the meal. Assistance was not offered by the health care assistants and none of the staff who we observed offered hand hygiene after the meal was finished.

Staff on both wards explained that napkins were not automatically given out anymore and that this practice had stopped last year.

The lunch was announced to all staff via a tannoy system on the elderly care unit which worked well. A red tray system was in use on the elderly care unit which identified people who required assistance at mealtimes. The manager on the stroke unit explained that red trays were not in use as ‘most patients’ on this unit required some form of assistance.

Food was stored in a mobile locker which was hot on one side and cold on the other. This meant that hot and cold choices could be served at the same time on a single tray.

The manager of the elderly care unit explained that there was no particular strategy

for meal delivery and said “staff just go where the work is”. When the meal arrived one nurse stated that she would “commence the feeds”.

Some patients had their dietary requirements documented on the boards behind their beds and we saw that staff referred to and updated this information.

Patients on both units were given trays which contained all three courses of the meal. Soup, main course and dessert were all served at the same time. Condiments were set out on each individual tray on the elderly care unit but not on the stroke unit where staff told us that they offered condiments to patients. We did not see any examples of condiments being offered.

We saw that some patients were asked if they wanted more food and that the health care assistants who served the meal were responsive to people’s needs. This included obtaining alternative meals and items not ordered from the menu, and changing cutlery to suit a patient’s preference. Staff sat beside patients to support them with eating and interacted well throughout the meal.

The mealtime on the elderly care unit was not fully protected from interruption as staff gave some patients their medication during the meal and one person was disturbed by an occupational therapist. There were no interruptions during the meal on the stroke unit.

Patients were offered a choice of hot and cold drinks. The food looked appetising and was well presented. The vegetables were of good natural colour and the pie looked to be good quality. Salads looked crisp and fresh and patients appeared to enjoy the taste. One patient had ordered a hot meal and a salad which they received and ate. Patients were offered butter on their mashed potato.

We observed that Pro Cal powder supplement was poured all over one patient’s meal on the elderly care unit and not mixed into the food before it was served to the patient.

The content of pureed diets had been separated on the plate into sections for meat, potato and vegetables. These meals were not well presented and staff told us that patients had commented that the pureed food did not look appetising. It was apparent that staff were aware that the use of food moulds was considered good practice to enhance the appearance of pureed food.

Overall, staff thought that there was a good choice of meals for patients to choose from. They described the food as being ‘too hot’ and how prior to service they had to remove lids and leave the meals to cool down. They added that they had to keep a regular check on the ordering system as sometimes it had lead to odd combinations of food being delivered.

Patients told us that ‘food was okay’, one felt that the ‘bread was tasteless and not very nice’. Others said that the food was satisfactory with ‘always plenty to eat’.

Another said that the food was good and well presented and that they were allowed to eat without being disturbed. A patient on the elderly care unit described the mealtime experience as 'quiet' and another described how staff had discussed their diabetic diet with them.

Patients who could manage the meal themselves were sat comfortably. However we saw examples on both units where dependent patients did not receive timely assistance. For example one lady had spilled her cup of tea onto her tray. We saw that she was upset and verbalised this but no one came to assist her. The patient told us that she was not sat comfortably and that she could not see her meal to eat it. Another patient who was in bed had no head or shoulder support. She could not reach her bed table and was unable to reach her drink.

The atmosphere on the stroke unit was busy and lively especially during the visiting period. The afternoon tea experience led by a ward hostess, was a very pleasant and relaxed experience for patients and their visitors

Staff told us that some food items were kept on the wards such as bread, cereals and biscuits to enable snacks and fresh toast to be provided. They said that the last meal of the day was served at tea time which was usually between 5.00 - 5.30pm. Drinks only were provided for supper but additional 'snack boxes' could be ordered. Staff described how the catering staff were open to providing alternatives according to patients' preferences and gave an example of where 'finger food' had been provided.

Other evidence

We met with a senior dietitian who told us that a dietitian was allocated to each ward. All food was prepared and cooked on site which the dietitian felt was a positive factor towards the quality and choice of meals. Also the daily provision of cooked breakfasts had proved popular and contributed towards improved nutritional intake.

The dietitian described a 'purple menu' system which was used for patients assessed as high nutritional risk and the red tray system used for patients who required assistance with their meals. Additional nutritious snacks would be provided for patients at high nutritional risk.

She detailed the use of the 'MUST' nutritional assessment tool throughout the hospital. Also the use of food charts and how these had been revised to assist staff to record detailed descriptions of food intake.

We looked at the care records for three patients on the elderly care unit. We found that these patients who had been assessed as having 'compromised nutrition' had not been nutritionally assessed during their stay on the emergency admission unit. However the MUST nutritional assessment had been undertaken when these patients had been transferred to the ward, which in all three cases had been within 48 hours.

We saw reference to people's nutritional history and known relevant conditions such as terminal illness within the records. Also early referral for dietetic and speech and language therapy (SALT) assessment and input which had been promptly provided. We were told that the designated chef for the ward discussed individual food preferences with the patients.

One patient had been thoroughly assessed with the useful input of their relative. Ongoing further, regular reviews took place and demonstrated positive team work between medical staff, dietitians and SALT.

The patients' records on the stroke unit showed that nutritional needs were assessed and body weights were monitored. The manager undertook to investigate an unexplained variance in one patient's body weight of over 3kgs in seven days.

Records were completed on both wards to monitor the food intake of patients who were under assessment or known to be at nutritional risk. We found that the standard of recording was variable and in some cases lacked clarity about the amount and type of food which had been taken. Entries included 'pureed meal, pudding and custard', 'ate half' and 'soup, main meal and pudding'. We saw several examples on the elderly care unit where there had been no documented intake on the patient's chart between 9am and 12 midday.

None of the patients were assessed as requiring a 'purple menu' service so we were unable to assess the recording of additional nutritious snacks.

We referred to our Quality Risk Profile where we hold all our information about the hospital. We saw that our information from the 2009 adult inpatient survey on the quality and choice of food provided, help with feeding and monitoring nutrition varied between similar and better than expected.

During this review the hospital provided us with their Action plan 2010/2011 in response to the 2009 inpatient survey. We saw updates which stated that patients were now able to choose small, normal or large portion sizes on the menu. Also that the provision of nutritional screening within twenty-four hours of admission was improving, although work was required to maintain improvement.

The hospital also provided us with detail of a 2010 audit into the effectiveness of a new system of snack ordering on two of the elderly care wards. We saw that an August 2010 Essence of Care Benchmarking report into nutritional care had found improvements in relation to mealtime care, protected mealtimes and mealtime assistance.

It detailed a need to continue providing/offering hand hygiene to patients prior to mealtimes and a need to improve the standards of nutritional assessment, care planning and reassessment, with particular emphasis on correct completion of the three day food diary.

There were no patient comments reported from the NHS choices website.

Our judgement

We found that patients were offered a healthy balanced diet and their nutritional needs were assessed and understood. However practices and support needed to be further developed to improve the mealtime experience and recording of food intake.

Action

we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	14	5 Meeting nutritional needs
Diagnostic and screening procedures	Why we have concerns: We found that patients were offered a healthy balanced diet and their nutritional needs were assessed and understood. However practices and support needed to be further developed to improve the mealtime experience and recording of food intake	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

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

The provider's report should be sent within 28 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

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

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	17	1 Respecting and involving people who use services
Diagnostic and screening procedures	<p>How the regulation is not being met: We found that the majority of patients were supported to make choices and had some opportunities to influence service delivery, but people were not consistently treated with respect and their dignity was compromised.</p>	

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

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

The provider’s report should be sent to us within 10 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

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

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

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

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

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

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

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

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

Dignity and nutrition reviews of compliance

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

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

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

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

Information for the reader

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