

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

## Addenbrookes and the Rosie Hospitals

Addenbrooke's Hospital, Hills Road, Cambridge,  
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2014

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

<b>Care and welfare of people who use services</b>	✓	Met this standard
<b>Cooperating with other providers</b>	✓	Met this standard
<b>Assessing and monitoring the quality of service provision</b>	✓	Met this standard

## Details about this location

Registered Provider	Cambridge University Hospitals NHS Foundation Trust
Overview of the service	Addenbrookes Hospital is a large teaching hospital which provides a full range of acute clinical services, including some further specialist services. The hospital provides over 1,000 beds. It is the main location for Cambridge University Hospitals NHS Foundation Trust. It is also designated as a major trauma centre.
Type of services	Acute services with overnight beds Diagnostic and/or screening service Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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## Summary of this inspection

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### Why we carried out this inspection

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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.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 7 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, reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

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### What people told us and what we found

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To help us assess the quality of care and service patients living with dementia experienced we visited the emergency department, the short stay acute medicine for older people unit, a specialist ward for patients living with dementia which also provided services for patients experiencing delirium and a general medical older person's ward. We identified patients who were living with dementia in all of these areas.

We spoke with 18 patients living with dementia, observed five other patients who were living with dementia, spoke with eight people who cared for people living with dementia, some of these were care staff from care homes accompanying people. We also spoke with 20 staff. We looked at 11 sets of records, and we looked at the care and treatment pathway for these patients to ensure patients' needs were met.

Most patients told us they received good quality care and were involved in decisions about care and treatment, this meant care was planned and delivered in a way which was intended to meet patient's individual needs.

Patients had access to a range of services to ensure their overall needs were met. The hospital staff worked hard to make sure they had the information they needed on admission to meet patients' needs effectively and to ensure an appropriate and safe discharge from hospital.

There were a number of systems in place to enable the trust to assess and monitor the quality of the service which were in line with national guidance on developing dementia care services.

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

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### **More information about the provider**

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

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

## Our judgements for each standard inspected

### Care and welfare of people who use services

✓ Met this standard

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

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### Our judgement

The provider was meeting this standard.

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

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### Reasons for our judgement

How are the needs of patients with dementia assessed?

We looked at the treatment documents and care plans of 11 patients who were living with dementia and found that initial assessments of their needs were completed on admission to the hospital and care plans were developed on admission to the ward.

Emergency department and ambulance staff told us that the majority of patients who were living with dementia were admitted to the emergency department by ambulance. The ambulance crew undertook an assessment of clinical need in the community and handed this over to emergency staff on admission to hospital. The medical and nursing staff told us some patients who were living with dementia did not come into the emergency department with any information and it could be difficult to obtain information directly from them; although we observed and heard staff attempting to do this in a kind and considerate way.

The assessments undertaken in the emergency department were brief and did not contain extensive detail about the patient and their needs. The assessments we saw were completed with essential detail such as the patients' communication, their manual handling needs, social situation, care set up, whether the patient was vulnerable and whether an assessment of their mental health was required.

There was a dementia case finding tool which was used to identify whether patients over the age of 75 had a known diagnosis of dementia or a previous documented acute confusional state. If there was neither the clinician was expected to undertake a short assessment of their memory (this was called the abbreviated mental test). These sections had been completed in the records of patients we spoke with to indicate they were living with dementia. Patients over the age of 75 years who showed signs of memory loss were assessed 72 hours after their admission. This helped ensure that such patients were identified, assessed, referred and followed up once they left hospital where this was

appropriate. We saw a specialist dementia nurse on the Short Stay Acute Medicine for the Elderly (AME) who was assessing patients living with dementia following their admission. This provided an example of the system working in practice.

A patient living with dementia and two relatives who were attending the emergency department told us the doctors had asked them a lot of questions to establish what had happened and what support they needed. One patient told us, "They asked me 100 questions but I have nothing but praise for people who are doing the job they are doing." A relative commented, "They have been lovely with [my relative], they have involved him in their assessment."

The assessments and care plans on the wards we inspected were more detailed. They included areas such as, the reason for admission, past medical and mental health history and presenting symptoms. We saw that consideration had been given to the level of the patient's awareness, whether a language interpreter was required and whether the patient had any needs associated with their hearing or sight. This meant staff were undertaking a sensitive and holistic assessment of patients living with dementia to make sure they could communicate their needs as effectively as possible.

Each patient on the emergency admissions unit (AME) had an admission booklet which assessed their risk of developing a pressure ulcer, their mobility and risk of falls, their nutrition and pain management. In the four records we looked at on the AME, all but one patient living with dementia had detailed assessment records. The information captured in the emergency department about the nutritional and pressure ulcer risks of one patient living with dementia had not been used to ensure continuity of care following their transfer to the AME. This meant that adequate control measures were not put in place to minimise risks to the health and wellbeing of this patient.

The forms used in the emergency department had a section for clinicians and nurses to complete on their assessment of the patients' pain. We observed emergency staff assessing patients' pain regularly and providing treatment for this promptly (when they were able to do so) and without significant delays. The patients we spoke with in the emergency department told us they were asked if they wanted pain relief.

We saw that pain assessments were in place for patients on the wards we inspected which also included an assessment of their non-verbal communication. We saw that a patient's level of pain was considered throughout the care planning process, for example when assessing the patient's moving and handling needs. During our observations, we heard staff asking patients to rate their pain on a scale of 1 to 10, in an assessment of the severity of the pain they were experiencing. This meant staff took the appropriate steps to determine if patients needed treatment to manage their pain.

How is the care of patients with dementia planned?

We saw the 'this is me' booklet was available in some of the patient files. 'This is me' is a practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests. This document should accompany the patient into and out of hospital. If the document was not available on admission the trust expected hospital staff to complete it during the patient's stay with the patient, carer and/or relatives. None of the booklets we saw had been fully completed. In some cases they were missing and when we queried this with staff they could not tell us where the booklet was or why it had not been completed. This meant that information about patients' preferences was not always

available for the staff to use when they were planning care, however we did not observe that this had an impact on the care being delivered to the patient.

We saw one patient had two completed booklets; one completed by the care home they were living in and one by the hospital. The information in these booklets was not the same and could lead to some confusion amongst staff who were delivering care to the patient.

We saw that care planning documentation had space to consider the emotional needs, fears or worries of patients living with dementia, but these were often not fully completed. We found limited evidence to show staff considered the emotional and psychological needs of patients living with dementia and how this impacted on and affected their health and wellbeing. We also found limited evidence of the consideration of the patient with dementia as an individual in their care planning. We saw that where patient's individuality was considered, this was mainly limited to age and religion, other issues such as culture, gender and sexuality were not actively identified and considered to ensure patients' diverse needs would be understood and met.

The staff we spoke with were able to describe the care and treatment of the patients we had case tracked which showed they had read and understood the care plans and could deliver care to meet those assessed needs. However, one member of staff told us that the plans of care were of variable quality and some contained more helpful detail than others. This suggested there was an inconsistent approach towards planning care which may have result in some patients not receiving the care and treatment they needed to meet their individual needs.

We spoke with staff about the use of advanced decisions, statements and care plans. These documents provided an opportunity for people to make their views known about their preferences so that their wishes could be taken into account in future care and treatment they received. Although most of the staff spoken with knew these were available, they said they were not well established and they rarely had to consider these when they assessed and planned patients' needs.

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

All of the patients we spoke with who were living with dementia were very complimentary about the manner of staff and said that they explained things to them. One patient said, "They've been very good. They've told me what's what but the balls in their court now."

Four patients confirmed they saw a hospital doctor regularly. Some could explain details of their condition e.g. one person knew they couldn't go home because their treatment was not yet concluded. Another knew they had a fracture and could tell us how it had happened. We heard the doctor explaining the treatment the patient would need to them and their family.

We observed staff engaging with patients, asking for their permission to deliver care and providing information about their care. Where patients were not able to help staff understand their views we saw records which demonstrated staff had involved their family in decisions about their care. One relative felt information about how their loved one was had been withheld from them and they felt this was not an appropriate response from staff as they did not live nearby. We checked this patient's records and saw that there had been an obstructive response from the staff member which could have inflamed a difficult situation. However we saw that the information had been passed on to the relative as they

had requested the following day.

Discussions with staff showed they had a good understanding of the challenges patients living with dementia faced when admitted into hospital. Some staff knew that patients' ability to understand what was happening may fluctuate. We saw that most staff explained patients' options and gave choices about their care and support. We observed that patients were asked for, and gave their consent before clinical procedures were performed.

Staff told us they used the body language of the patient living with dementia to help to understand their needs. However, we did not find this information documented in the care plans to make sure all staff understood how each individual patient expressed themselves. Staff also told us they were getting pictures of specific tasks and food from the menus to help staff communicate with patients with dementia. This was not yet in place and could not assist staff to ascertain the choices of people living with dementia.

We saw patients were offered a choice of what to eat and drink. One patient we observed had a diagnosis of dementia and it was not clear from our observations that they were provided with the support and choice to meet their nutritional needs effectively. This patient was nutritionally at risk and ate only a very small amount of their meal with encouragement.

We asked four members of staff about how patients living with dementia were supported to be involved in decisions regarding their care and treatment. They told us there was a dementia champion on the ward, whose role was to develop the understanding of staff in order to work more effectively with patients living with dementia. The dementia champion told us they had recently taken on this role, and demonstrated an excellent understanding of person-centred care.

Seven of the patients we spoke with were able to give examples of how they made choices such as what to eat and drink, whether to have pain relief, what to do during the day and when to ask for assistance. However two patients told us the staff told them when to get up and they felt they did not have a choice in this and had to do as instructed by staff.

How is care delivered to patients with dementia?

We saw and heard of some innovative practice in terms of identifying how best to deliver care and treatment to patients living with dementia. For example, this had been very carefully considered in the emergency department where the dementia champion was extremely pro-active.

This member of staff had identified how confusing, upsetting, noisy and disorientating the emergency department could be for patients living with dementia and they had identified with staff and clinicians the most appropriate areas to locate patients with these needs. We saw these were quieter, less busy areas or side rooms away from the main activity of the emergency department. We observed that consideration had been given to where to locate the patients living with dementia we spoke with and they were in the areas staff had identified to us.

The dementia champion for the emergency department wanted to expand this work further to make the experience of hospital easier for patients living with dementia and intended to develop and provide rummage boxes, drawing and reminiscence items to help occupy

patients whilst they were in the emergency department. This showed a considered approach towards the delivery of care and treatment for patients living with dementia.

There was a team focussing on frail older patients who had been admitted to wards. They aimed to carry out an assessment within four hours of ward admission to establish further support required. They told us they worked closely with other agencies within the hospital including the falls team, and occupational therapists. Part of their role was to ensure support was provided when it was needed. There was also close liaison between this team and the short term assessment and rehabilitation team to ensure patients had the support they needed before being discharged back into the community. Staff we spoke with were positive about this team and their work and said they were excellent at co-ordinating patients' assessments.

We saw some wards had considered the environment and how to make this more appropriate for patients living with dementia. For example, we saw that the entrance to the bays on one ward had been painted different colours to help patients orientate themselves and to help them locate their own bed and belongings. We also saw toilet seats were red to make them more visible and there was some signage on the ward to help direct patients living with dementia. In some of the bays, we saw that beds had been removed to make room for a table. Staff told us, this table was used to support patients to sit in a group setting, for example, to eat their meals or to play games, when staff had the time to do it.

The layout of the ward enabled two staff to be allocated to each bay. We observed that at least one member of staff was present in a bay for most of the inspection which meant they were on hand to respond to patients' needs. Four patients said that staff were good, "but very busy," and that, "they didn't have time to talk much." We observed one member of staff playing a board game with a patient (who had chosen the game).

We saw many positive interactions between staff and patients including where patients were supported when they became upset, when they were disorientated and when they expressed pain although interactions were mainly limited to clinical tasks. Staff regularly checked that patients were comfortable in their chair or bed. We also saw that patients mostly received care and support from staff in a timely and responsive manner.

There were also occasions where staff did not support people in a way that demonstrated their understanding of current good practice in dementia care. One staff member who was encouraging a patient with dementia to eat their meal told them, "Eat your food or the doctor won't let you go home." This was an example of coercive and deceptive practice. Another staff member called a mature patient with dementia a, "Good girl," when they accepted the spoonful of food offered which was not dignified or respectful. On one ward we also observed staff talking about patients in front of them about their care and treatment, without engaging the patient in the conversation. We shared these concerns with ward and trust managers.

We saw that the staff were at times busy and rushed and there was one less nurse on duty on the AME than there should have been according to the duty rota. The senior staff said the hospital did what they could to ensure there were enough staff. However on this particular day, a member of staff who had been scheduled to work on the ward had been sent to work on a different unit and had not been replaced. There was a student nurse and another student on placement on the AME who both assisted with patient care tasks such as assisting patients to eat and drink.

On another ward staff told us that if there were significant risks to patients because of the risk of falls or changing behaviour additional staff were available to provide a closer level of monitoring of the patient. Staff told us that these patients were often monitored by staff who were not permanently based on the ward (bank staff). However, they told us the bank staff did not always know the patient sufficiently well and they need guidance from the staff on the ward to deliver care safely and effectively to meet the patient's need. They also told us there were times when there were insufficient staff to perform the close monitoring of patients at the frequency identified in their risk assessment. This meant there was a risk that patients may receive inappropriate or unsafe care.

We observed that support was not always delivered as it had been planned and at this meant there was a risk patients may not receive appropriate care. For example we saw that a patient's care plan stated they were refusing all meals and had to be offered regular snacks. We saw no evidence of snacks being offered to the patient during our observations.

Some of the staff we spoke with did not demonstrate an awareness of the National Institute for Clinical Excellence (NICE) guidelines on dementia. These are research based guidelines about best practice in relation to dementia care. One member of staff we spoke with told us they gained their knowledge through observing the consultants on the ward and reading about dementia in books and journals.

Is the privacy and dignity of patients with dementia respected?

All of the patients we spoke with said they were treated politely and with dignity and respect. We observed patients being spoken to in a respectful manner, though we did note one or two staff used terms of endearment rather than patient's names. Staff interactions were generally courteous and staff were observed positioning themselves so that they were at the same eye level as the patient and not standing over them.

Ensuring patients' privacy in an open ward presented challenges for staff. Patients' personal care and treatment needs were carried out behind curtains to protect their privacy and dignity. However, it was difficult to maintain confidentiality as discussions about their health care needs and plans were held under these circumstances. The wards we inspected had private rooms for meetings and quiet times.

We observed doctors speaking with patients living with dementia introducing themselves and telling the patient where they were and why they had been admitted. They explained the treatment they had received and the next plans. They checked the patients' understanding and gave them time to respond.

There were no visible symbols to show patients who were (for example) at risk of falls or who had memory loss above their bed. This increased the likelihood of the patients' needs being frequently discussed which compromised the privacy and dignity of the patient.

We spoke with four members of staff about the steps they took to ensure patients were treated with respect. They told us they identified patients' likes and dislikes, so that they could respect these whilst the patient was in the hospital. Staff in the emergency department told us they received training on dementia care on a regular basis. They told us a right to challenge colleagues' practice existed and was encouraged amongst staff throughout the hospital. Senior ward staff told us they observed the body language of new members of staff, and used this to ensure the ethos of the hospital was maintained and

unprofessional behaviour was not allowed to develop.

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

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**Our judgement**

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The provider was meeting this standard.

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

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**Reasons for our judgement**

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

One patient told us they knew they needed extra support on discharge from hospital and indicated this had been discussed with them. The patient said, "I can't go home, I don't know where I'll go but I can't look after myself anymore."

We identified inconsistency in the range and quality of information care homes sent into hospital with patients living with dementia. In some cases we saw a communication passport or a 'this is me' booklet had been sent in which detailed the person's social, medical and mental health needs, their wishes, preferences and how they expressed their needs through their behaviour. The nurses and clinicians in the emergency department and on the wards told us this helped them understand the person, their needs and the care and support they may need whilst in hospital.

In other cases we found the information provided from care homes was not adequate. We saw one patient who had been admitted to the emergency department with a pre-admission assessment which was over a year old. This indicated the patient had a range of needs which would need attending to, such as pressure ulcers, poor mobility and behaviour which was changeable. We observed the doctors having to contact the care home to check whether the information was still accurate and up to date. This provided a significant challenge for the staff at the hospital in terms of being able to accurately identify what care, support and treatment the patient may need for pre-existing needs when they were admitted to hospital. The actions taken by staff working at the trust however were proactive and protected patients against the risks of receiving inappropriate or unsafe care or treatment.

Staff we spoke with told us care homes were better at sending patients living with dementia in with an escort than previously, but patients still came in alone at times which meant it could be difficult to get a clear history and an idea of the patients' needs. We observed, however, that even in such circumstances the staff took the time to try and speak with the patient about their needs and history.

When information was sent in from a care home we saw this had been used by hospital staff to try and identify the needs of the patient. For example we saw staff arranging for specialist mattresses and falls risk assessments in the emergency department to meet people's needs. The staff we spoke with told us they would contact the patient's care home if they observed a change in the patient's behaviour. They also told us they would report the behavioural changes to the doctor, as they could be associated with, for example, an infection to make sure they received prompt treatment.

Staff we spoke with told us when patients moved from the emergency department to a ward, their individual assessments transferred with them. Staff told us there was good liaison between departments and wards when patients moved to ensure the staff had a summary of the patient, their needs, and knew whether they were living with dementia. We observed the doctors in the emergency department contacting ward staff and telling them about the needs of the patient being transferred to them in some detail to make sure these would be met.

Staff we spoke with told us there had been developments in the creation of co-ordinated systems for the care of patients living with dementia and the implementation of new care pathways but these had not yet been completed.

There were two hospital teams who co-ordinated care for patients and planned and arranged their discharges. One focussed on frail older patients who had been admitted to wards. They aimed to carry out an assessment within four hours of admission to the ward to establish what further support was required. They told us they worked closely with other agencies within the hospital including the falls team, and occupational therapists. The other team offered an integrated, fast access, health and social care team which provided a pathway to community health and social care services for patients. The team provided information, liaison and advice on discharge planning to bridge the gap between hospital and community services.

We saw how hospital discharges were planned for patients with dementia who were returning to a care home or were moving into a care home. Continuing care assessments were undertaken by two trained staff. The purpose of these assessments was to decide if funding for nursing care was required on discharge. There was a discharge team who worked with the ward staff. They began to plan patients' discharges soon after admission. We saw evidence to show care homes had been contacted to share information about a patient's needs and to advise the care home how to meet their needs.

We found that prior to discharge from the hospital, staff ensured that all necessary actions were finalised to ensure the ongoing safety and wellbeing of the patient. During our observations, we saw staff preparing the patient for their transfer home, including speaking with the patient, as well as contacting relevant services on the ward. Staff we spoke with confirmed that when the patient moved from the hospital into their care home, the completed 'this is me' document went with them to their next place of stay to enable continuity of care.

We met one patient whose planned discharge had been delayed because their individual circumstances meant they were not able to return home. They remained on the AME for longer than the average stay so that appropriate discharge arrangements could be made. This meant that the staff acted in the best interests of the patient to manage the risks associated with a potentially unsafe discharge.

The staff we spoke with told us there were a number of different support options available when a patient had a diagnosis of dementia. These options included contacting the psychiatric liaison nurse or the dementia specialist nurse. We were told that the dementia specialist nurse had done some night shifts on the dementia care ward, to help understand the needs of the patients on the ward.

We saw that volunteers were involved to work alongside the hospital staff to support patient care. One staff member told us, "Volunteers are going to come and read to people. We are just waiting for our volunteers to get their training". This meant that the trust was working with voluntary organisations to improve patient care.

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

There were notice boards and other points around the ward with accessible leaflets and other information about support groups at the hospital and in the community. Information was available about social services and voluntary organisations. This included guidance on accessing support for people living with dementia and their relatives. This meant that patients and their relatives were provided with information about the different types of health and social care support available to them.

We reviewed discharge planning records in patients' files. One patient had received a range of assessments by different health care professionals on AME and the evidence from these suggested that they required 24 hour care and support.

We saw that patients were referred to other health care professionals such as occupational therapists and physiotherapists. Consideration was given to the referral of one person to the dietetic service however, this person was discharged so their care home was contacted to recommend this course of action. Social workers were involved in continuing care needs assessments and we saw records from meetings with patients to discuss the person's future care needs and how they would be met.

We saw that one patient at the point of discharge from the hospital, had been assessed for ongoing social care support at home, transport, re-enablement services, pharmacy and occupational therapy involvement. Staff showed us the referral form which was used to assess patients' need for health and social care services in the community. This considered whether the patient was medically stable at home, safe overnight, whether the referral had been discussed with the patient. The referral form included an assessment of the patients' mental state. This meant that patients received specialist assessments giving them access to services to meet their health and social care needs.

## Assessing and monitoring the quality of service provision

✓ Met this standard

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

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### Our judgement

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The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

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### Reasons for our judgement

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How is the quality of care monitored?

The trust took part in the Royal College of Psychiatrists' National Dementia Audit and we were provided with a copy of the most recent report dated February 2013. We noted that the trust performed well compared to the national average in the areas assessed.

The trust had a plan detailing the actions that they were to undertake as a result of this audit. Several actions had already been completed. These included dementia awareness training being incorporated in all staff induction programmes and patients having 24 hour access to the liaison psychiatry service.

The trust had a multi-disciplinary dementia care steering group in place to provide strategic direction, co-ordinating all aspects of dementia care and training. The arrangements for training were being rolled out and the trust told us these would be specific to staff role and designation. The impact of these initiatives could not be fully assessed as the training plan had not been fully rolled out yet.

The trust also had a Liaison Mental Health Team for Older People; staff in this team highlighted the needs of older people with mental health problems in the hospital and ensured that their needs were met. This team was responsible for reviewing patients' medication and providing advice and guidance to staff, relatives and patients about managing behaviour changes and the symptoms patients living with dementia could experience.

The dementia specialist nurse told us about the dementia care pathways which were in the process of being developed in the hospital. The assessments of patient needs undertaken were allied to the National Dementia Strategy and the Commissioning for Quality and Innovation (CQUINs) payments framework. This meant that the trust was using national dementia guidance to help design their approach to dementia care.

The trust had in place a number of training courses and different initiatives to ensure staff

across the trust had the skills and knowledge to support patients living with dementia. Although not all staff were aware of the current National Institute for Health and Care Excellence (NICE) quality standards on dementia care there was clear evidence that the trust were working in line with national guidance in developing their dementia care services.

There were elements of good practice, designed to ensure and assure the quality of dementia care across the hospital. For example, dementia champions had been identified on all of the wards and areas we visited. These staff had been appointed to be responsible for the improvement and monitoring of the quality of dementia care at the hospital. The trust had not yet fully analysed the impact of having dementia champions and as such had not yet identified areas of excellent practice in order to share this with other units where the dementia champions felt they were having less of an effect on service delivery. The provider may wish to note that as this variability had not been identified the service being provided on different wards was inconsistent and patchy in terms of the quality of dementia care.

We identified areas where significant developments in dementia care practice had been made. The emergency department for example had a considered approach towards providing care and treatment for patients living with dementia which had included a close scrutiny of the emergency department environment. As the department had obtained some money the dementia lead was looking to further enhance the environment to help patients living with dementia cope with being in a busy accident and emergency department.

The staff we spoke with told us the dementia care lead held weekly training and discussion sessions with staff in the emergency department, encouraging them to consider the environment and the challenges it would present for a patient living with dementia. They all told us they valued these opportunities to examine their practice and the way the unit worked. However, this approach was not consistent on all the wards and units we inspected. Some of the staff we spoke with were aware of the different stages of dementia; others told us they had only received dementia awareness training and there had been no further development of their understanding and practice.

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

During our inspection we met with representatives from the patient safety team. They informed us about the incident reporting system that was in place in the hospital and we saw a breakdown of all incidents involving patients living with dementia. The incidents were broken down into the categories of falls; patient care, patient movement, security and others. Each incident was classified as minor, moderate or major depending on the impact on the patient and organisational risk.

We saw there was evidence of learning from incidents. We saw all major incidents had been analysed and a root cause analysis had been undertaken to enable the trust to identify, assess and manage risks to patient safety. Patient safety managers told us they read every incident form with a view to identifying those which needed to be escalated for further investigation. This demonstrated a good level of oversight and scrutiny existed at the trust to enable them to identify, assess, learn from and therefore manage risks.

Most of the qualified nurses we spoke with knew about near miss and significant event reporting. (This is where unexpected or untoward incidents which did or could have an impact on patient care or safety are recorded and reported to try and learn from events

and prevent them happening again.) The staff we spoke with told us they did not have access to information about the events on their individual ward as these were held centrally. The qualified nursing staff were better informed about significant events than the health care assistants who said they would find this information useful to their work and learning.

Are the views of patients with dementia taken into account?

During our inspection we met with a representative from the patient advice and liaison service (PALS) who told us the themes and patterns of complaints were always analysed to identify any areas of under-performance in the trust. The person we spoke with told us there were no identifiable patterns or themes in patient feedback relating to the quality of dementia care.

The member of staff from PALS told us that in their view, the trust listened to patient feedback and always acted upon this to improve outcomes for patients. They told us they would request an advocate for any patient who did not have a known next of kin or if they lacked the capacity to make their own decisions. This showed active consideration was given to protecting the rights of patients.

We reviewed recent complaints which had been received and the action plans which the trust had put in place to address the issues and improve the quality of service being provided. Actions taken included; more comprehensive handovers on wards and units, further training of staff in the use of the 'this is me' information booklet, an increase in staffing levels on one ward, and additional staff training. The member of staff from PALS told us this feedback was always shared with the relevant wards.

With a few exceptions, members of staff working at the trust usually took account of patients' choices and preferences and decisions about their care and treatment. Staff we spoke with told us that feedback was requested from the relatives of patients who showed suspected symptoms of dementia using feedback forms. This feedback was not routinely requested from patients themselves and the feedback forms in use were not yet written in different formats. This meant that the views and experiences of patients living with dementia were not always being captured to ensure the trust took account of their views.

## About CQC inspections

We are the regulator of health and social care in England.

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

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

**✓ Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

**✗ Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

**✗ Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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**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.

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**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.

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**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

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We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

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### **(Registered) Provider**

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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'.

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### **Regulations**

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We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

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### **Responsive inspection**

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This is carried out at any time in relation to identified concerns.

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### **Routine inspection**

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This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

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### **Themed inspection**

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This is targeted to look at specific standards, sectors or types of care.

## Contact us

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