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

**Wythenshawe Hospital**

Southmoor Road, Wythenshawe, Manchester, M23 9LT

Tel: 01612912023

Date of Inspections: 21 January 2014
20 January 2014

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

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## Details about this location

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<th>Registered Provider</th>
<th>University Hospital of South Manchester NHS Foundation Trust</th>
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<td>Overview of the service</td>
<td>Wythenshawe Hospital is a large teaching hospital with approximately 950 beds. It provides acute medical services and specialist care including cardiology and cardio thoracic surgery, heart and lung transplantation, respiratory conditions, cancer and breast care services. The hospital is located in Wythenshawe approximately six miles from Manchester city centre.</td>
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| Type of services | Acute services with overnight beds  
Community healthcare service  
Long term conditions services |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Management of supply of blood and blood derived products  
Maternity and midwifery services  
Nursing care  
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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 20 January 2014 and 21 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 talked with local groups of people in the community or voluntary sector. We were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

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

Wythenshawe Hospital is a large teaching hospital with approximately 950 beds.

During our inspection we visited the Emergency Department, the Clinical Decision Unit (CDU), assessment wards A5 (Orthopaedic trauma), A6 (General surgery and surgical assessment unit), A8 (General medicine), A9 (Specialist Gastroenterology ward) and wards F3 (Urology), F4 (Complex social care needs) F7 (Rehabilitation), F15 (Stroke) and Oncology ward. We spoke with 8 patients who had dementia or possible dementia and their relatives. We also looked at the care records of thirteen patients with dementia and staff who were on duty in all of the areas we visited.

We saw that patients were assessed on arrival at the hospital and on admission to the wards. Patients were placed on an appropriate care pathway although we found no special dementia care pathway in place. All patients over the age of 75 years of age were assessed for signs of dementia on admission to the hospital.

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During our inspection we visited the Emergency Department, the Clinical Decision Unit
We saw that patients were assessed on arrival at the hospital and on admission to the wards. Patients were placed on an appropriate care pathway although we found no special dementia care pathway in place. All patients over the age of 75 years of age were assessed for signs of dementia on admission to the hospital.

We found that staff had not received any specific training in dementia although we observed that patients with dementia were kept safe because their risks were appropriately managed by caring staff with good personal skills. We saw that staff provided care in a responsive and unrushed manner. Patients and their relatives told us they were treated with care and compassion. One patient said, "I have been treated very well".

Staff worked closely with other providers and services as much as possible to ensure that specialist assessments were completed and safe hospital discharges were facilitated. However the hospital could be more proactive in its work with other agencies.

A plan was in place to improve dementia care however systems to assess and monitor the improvement plan were not ensuring this plan progressed. Systems had not picked up a lack of recording around dementia assessments on records we looked at and systems to monitor risk were not effective and lessons were not learned.

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 13 May 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>
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<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
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**Our judgement**

The provider was meeting this standard.

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

**Reasons for our judgement**

How are the needs of people with dementia assessed?

On arrival at the hospital Accident and Emergency Department (A&E), a full medical history was obtained by staff through speaking with the patient or the patient’s carer. During this initial assessment, people with a known diagnosis of dementia were identified and a note made on their record. Staff we spoke with all had some understanding of how to provide basic care to patients who live with dementia. No staff in A&E had received any specialist training in dementia although one nurse did tell us that they were aware of the trust’s dementia nurse specialist and told us that if they required any help then this would be their first point of contact.

The Trust was meeting its Commissioning for Quality and Innovation (CQUINs) payments framework requirement for Dementia. That is to say all patients over the age of seventy five years of age, admitted to the hospital were assessed for dementia by the lead dementia nurse for the trust. Staff informed us that the lead nurse for dementia was in the departments and wards every day and had nothing but praise for this person who they found to be a useful and knowledgeable contact. We were informed that there was a process in place to refer patients who screen as having memory problems to a lead consultant for dementia. This meant that staff had regular contact with the trust’s lead nurse for dementia for advice and support to treat patients with dementia.

How is the care of people with dementia planned?

The ward staff we spoke with were aware of the Forget-Me-Not Scheme to discreetly identify people who required additional support as a result of their dementia. All the staff we spoke with were aware of the purpose of the forget me not symbol. We did find that detailed knowledge of this scheme differed from ward to ward. For example on one ward we found extensive knowledge of the scheme with information displayed on notice boards and staff were able to show us a ‘memory box’ put together by the dementia champion for
the ward. On another ward staff spoken with understood what the scheme was about and who the dementia champion was however we found no physical evidence such as a memory box on this ward. This meant there were different levels of knowledge about this scheme throughout the wards.

We saw from patient records and nursing notes we looked at that where a diagnosis of dementia was recorded there was no recorded evidence of further review and or follow up to this diagnosis to indicate what further action should be taken. One staff member told us that a referral would be made to the lead consultant for dementia. Staff we spoke with on one ward were unable to tell us what further action would be taken in respect of a person's dementia. We spoke to senior members of the trust about this. We were informed by senior staff that anyone found to have dementia would be referred to the trust's lead consultant for dementia. This meant that any ongoing dementia related referrals were not recorded on patient's notes which made patient records inaccurate.

We looked at recordings in patient notes for people with dementia. On one record we saw the comment recorded: "Patient suffers from dementia therefore cannot tolerate head dressing". There was no other explanation around this statement. We were unable to establish what was meant by this statement and if there was an apparent lack of knowledge around dementia amongst staff. None of the staff we spoke with during our inspection had received any formal training in dementia. There had been an awareness event held recently and staff were able to tell us that there was some e-learning training now available on dementia. We were told by staff on one ward that there was an induction programme that included dementia care information for new staff. However, senior staff on this ward were not fully aware of the content of the induction for new staff and on how to follow up their training in ongoing supervision. We were informed by senior staff that there is an intention to make dementia training mandatory. This meant that some staff had not had sufficient training to fully understand dementia.

On one person's record we found reference to agitation, self-harm and expressing wishes to die. Other than a recording which stated: "Cutlery removed and doctor informed", there was no evidence recorded as to what support, de-escalation or care planning around these concerns had taken place. This meant that follow up information about this patient's care was not available for the staff to use in future care planning.

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

We saw that staff gave patients choices about their care and support. Patients were asked what they wanted to eat and drink, and if they wanted support with their personal care. This meant that patients were involved in making decisions about their care and treatment.

Relatives told us that they were very involved in the care once the patients were on the wards. One relative did tell us that whilst they felt very involved in the care of their relative, they had not spoken with a doctor for some weeks as a doctor had not been available at the time of their visit. The provider may wish to consider ways in which communication between clinicians and relatives could be improved.

Some patients with dementia were unable to make decisions about their care and treatment. Staff we spoke with were able to articulate the main points of the Mental Capacity Act 2005 (MCA) and in particular the aspects relating to people who were unable to make specific decisions around their care and treatment. The MCA provides legal safeguards for people who may not have the capacity to make some decisions for
themselves. We were told by staff that when patients could not make decisions for themselves, appropriate representatives were consulted with, to ensure that decisions were made in patient's best interests. However although we saw references to best interest decisions on patient's records, we saw no written evidence that capacity tests had been completed and best interest decisions made as a result of consultation. For example we found on one person's record, who had been diagnosed with dementia, that risk assessments were in place for moving and handling, falls, skin integrity and nutritional status. However there was also a bedrail assessment in place which was documented "consent not gained" and a box checked 'in patient's best interests'. We saw no evidence of any capacity test around this decision or evidence of any involvement of relatives, clinicians or other people with any vested interest in this persons care and treatment. This meant that decisions made around people's capacity to consent and subsequent best interest decisions were not recorded.

Are people with dementia provided with information about their care?

We saw that information from voluntary organisations was displayed in corridors and ward areas. This information also included information about dementia and the support that was available to people. Staff we spoke with told us that they consulted with patients about their care. We saw that staff gave patients information in a manner that reflected their communication skills and levels of understanding. Relatives we spoke with told us that they had been involved in the care of their relative and felt informed. This meant that staff spoke to patients with dementia about their care and treatment but where this was not possible involved their relatives or carers. We saw no evidence recorded in patients records that people with dementia had been involved in their care planning or had family friends or advocates consulted about their care and treatment. The provider may wish to remind staff to record such interactions.

How is care delivered to people with dementia?

All of the patients we spoke with and their relatives told us they were happy with the care provided. One patient whom we spoke with in the discharge lounge was waiting to return to their care home. This person appeared well presented and relaxed. They told us that they had been "treated very well". Another person told us: "In my opinion, one hundred percent caring and are A-rated as far as I'm concerned in how they care for [my relative]". This meant that patients and their relatives we spoke with were happy with the care received at the hospital.

Throughout our inspection, we saw positive interactions between staff and patients, and we saw that patients were treated with care and compassion. For example on one ward we observed a patient being assisted to remain safe as their spouse went to meet them. Staff calmly explained to the person that they might just stay where they were or even better sit down to avoid any fall. On another ward we saw a member of the nursing staff sat next to a patient who had dementia assisting them to read. We did not at any time during our inspection observe any poor care. We saw staff support patient's when they were distressed and we saw that people were assisted to achieve a comfortable position in their chair or bed. We also saw that patients received care and support in a timely and responsive manner.

One senior ward staff member did tell us: "There is a specialist team. There is an awful lot going on at present. There is a clinical lead nurse specialist. We have lots of training aids, done full dementia day. Lots of work is being carried out regarding the environment
[named nurse] is the link nurse for the ward". "Staff have had some study days on the ward – ‘forget me not cards’ etc. Cutlery, colours and pilot ward for care companions”.

Throughout our inspection patients, relatives and staff were invited to make comments on the care people with dementia received in the hospital. We placed comment cards and posting boxes in a number of places throughout the hospital. The boxes were left in situ for a period of seven days after our visit, they were sealed and only to be opened by us after collection. This meant that the anonymity of people who made comments would be protected.

Relatives comments from these boxes included: "I felt the hospital provided an excellent care service for my Grandma with Dementia. I found all the staff extremely helpful at all times and caring”.

"In the two weeks my wife who, has dementia, has been in here I can say her treatment and nursing has been excellent, the staff have pulled out all stops to ensure she is continually under supervision". And:

"Tender loving care is given to patients I have been in contact with, but I think the nurses need more time to deal with these special patients".

Comments from staff included: "I feel the needs of the patients with dementia on this ward is given to the best or our abilities, however when we are short staffed not enough time can be given to the individual".

"Overall I feel care provided to people with dementia is good. Sometimes I feel due to time or staffing constraints that care could be better. I think that overall care needs are met and people are treated with compassion and regard". And:

"Dementia care is improving on the ward with the introduction of care companions and staffing levels also training is now available and staff are more aware".

Is the privacy and dignity of people with dementia respected?

We saw that patients were treated with dignity and their privacy upheld. We heard staff address people pleasantly using first names. Patient’s personal care needs were met behind curtains or behind closed doors. For example in the accident and emergency department we were informed that one person, recently admitted, had given consent to us speaking with them. This person was in a cubicle for privacy and appeared comfortable with blankets in place to keep them warm and protect their dignity even though the department was extremely busy at the time. All of the patients and relatives we spoke with told us they were treated with privacy and dignity. This meant that patient's privacy and dignity, whether they had dementia or not, was respected by staff.
Cooperating with other providers

Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

We found during our inspection that patients who had entered the hospital after an emergency had their necessary information given to staff by relatives and carers who had accompanied them to the hospital.

When someone entered the hospital from a care home, hospital staff relied upon information provided to them by the home in documentary form or by an accompanying carer from the home who had travelled with the person. Records seen indicated that this information was not always available. Other than a medication administration record (MAR) on one person's notes we found no evidence of information being provided to the hospital from care homes. This meant there was no system in place to obtain a full history about people brought to the hospital from care or nursing homes.

We saw that staff worked with other services to plan hospital discharges. The hospital had a dedicated discharge team which had staff from the local area social services attached to it. The hospital received patients from a number of the social care areas in Manchester and the hospital had been proactive in getting the different social work teams to work together to assist in the safe discharge of patients. We did note that there were no dedicated staff from the mental health trusts included in this team which would have helped to facilitate the discharge of some patients with dementia to placements which would meet their needs. A number of patients with dementia on wards we visited were clinically fit for discharge but were remaining on wards waiting for the availability of an external placement to meet their needs. For example one patient had been in the hospital since November 2013 and had been waiting for discharge for a number of weeks. One member of staff told us that when they got support from the mental health team the support was good, but the problem was the lengthy wait for a response from this team. This meant that space in the hospital was limited which in turn caused disruption in other parts of the hospital such as backlog in the accident and emergency department.

We saw that staff worked with other services to gain and share information to facilitate
patients discharge from hospital. This proved more difficult when dealing with patients from outside of the catchment area of the hospital as staff were reliant on outside agencies to facilitate discharge. For example one relative described how lack of protocols between area services caused delayed discharges. We were told that their relative was in fact 'bed blocking' as the accident had happened out of their own area. Whilst they stated their relative had received very good care at Wythenshaw, they had been waiting since October 2013 to secure residential care for their relative. Social services in their own area could not spare a social worker to travel to carry out an assessment. Whilst it had now been agreed that the assessment could be carried out by a commissioned social worker the delay had caused great stress to their relative and them.

On the first day of our inspection the accident and emergency department was extremely busy. At one point we observed six ambulances waiting in the ambulance triage area. These ambulances had been assessed by the two triage nurses working in that area. However, there was no capacity to accommodate them in cubicles. At approximately 14.55 on 20 January 2014, 8 patients were still waiting to come through from the waiting room but had been delayed due to no capacity. 80 patients had been registered as being in the department at this time and the department was on RED status (This was one stage below a full emergency). We observed that staff in the department were working as well as they could. There were sufficient numbers of staff and clinicians available. The cause of this hold up in the accident and emergency department was due to lack of capacity within the main hospital due to delayed discharge of patients from the wards. We saw that staff from North West Ambulance Service and hospital managers were working together to ease the situation.

Staff at the hospital wrote discharge summaries in the form of a letter for the patient's, their carers and their GP. The letter would set out both treatments and any other dementia issues that had arisen during the patients stay in hospital. Relatives we spoke with told us that this information was very useful for families or care homes when they supported people after discharge. This meant that the hospital provided relevant information to other agencies and professionals to assist in peoples care after discharge from the hospital.

We saw that volunteers were available in the outpatient's area. Most people with dementia in outpatients arrived with a relative or carer. The presence of the volunteer information service and volunteers in this area did help to support people sensitively through the check in and waiting systems. This meant that the trust was working with voluntary organisations to improve patient care.

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

All patients over the age of seventy five years of age, admitted to the hospital were assessed for dementia by the lead dementia nurse for the trust. We were assured that anyone who was thought as a result of this assessment, to have some form of dementia would be referred to their lead consultant on dementia. We did see from records we looked at that patients were referred onto health and social care professionals, such as; occupational therapists, physiotherapists, speech and language therapists, dieticians and social workers appropriately. This meant that people received specialist assessments and treatments to meet their health and social care needs.

We saw that information from voluntary organisations was displayed in corridors and ward areas. This information also included information about dementia and the support that was available to people. This meant that patients and their relatives were provided with
information about the social care support available to them.
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 not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a moderate 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

A review of the majority of risk and governance systems in place was undertaken via document review, interviews with staff and review of the ‘Ulysses Risk Management System’ used by the trust. The inspection team assessed implementation at ward level. As this was part of the dementia themed inspection programme, specific examples of the governance around dementia were requested and reviewed.

How is the quality of dementia care monitored?

The Trust was meeting its Commissioning for Quality and Innovation (CQUINs) payments framework requirement for the Dementia. That is to say all patients over the age of seventy five years of age, admitted to the hospital were assessed for dementia by the lead dementia nurse for the trust. Staff we spoke with on the wards informed us that the lead nurse for dementia was in the departments and wards every day. However we found no evidence of this assessment having been completed on any of the patient records we viewed. We spoke with staff on the wards about this who confirmed to us that the lead nurse for dementia had completed the assessments. We therefore asked staff on the wards to show us the records of patients that they knew to have had an assessment completed by the dementia nurse. We looked at four further records which were shown to us. However the staff could not find the assessment document on patient records either. We spoke with the lead nurse for dementia about this process. We were told that lead dementia nurse currently sees everyone over 75 and completed an assessment. There was a process in place to refer patients who screen as having memory problems to a lead consultant for dementia. This person then sends letters to GPs as appropriate to ensure ongoing referral to memory clinical or follow up. We explained that we had not seen any of these assessments on the patient records we had looked at and were told that this person had a list of people to see and showed us the documentation used which was placed on patient notes. We again explained to them that we had not seen any of these assessments on any patient notes. The lead consultant for dementia was available to speak to on the day, but we declined the opportunity to meet with this person as the lead
nurse for dementia being the person who completed the assessments had provided us with sufficient information. This meant that the process for recording dementia assessments was not evident on the records we looked at therefore the trusts systems had failed on this occasion to pick up on the lack of recording of dementia assessments on patient's notes.

The Trust had completed a review of itself at the beginning of November 2013. The Trust had invited in representatives from up to 14 different organisations as part of this review. The Trust had used the feedback from this review to develop an action plan and was able to show us evidence of this action plan starting to be implemented.

The Trust had also commissioned external auditors to undertake a review of its structures against Monitor’s Quality Governance Framework. This was conducted to provide the new Chief Executive and Director of Risk and Governance with a baseline to improve upon. The Trust shared the full findings with us along with their actions to date. The current position is that there are improvements to be made. This meant that the trust had been proactive and taken steps to obtain relevant professional advice to improve the way it monitors the quality of service provided.

We looked at the governance structures around dementia as part of this inspection. The Trust provided a Dementia Action Plan, Dementia Carer Survey Action Plan and an Educational Plan. The Dementia Operational Group had responsibility to monitor the delivery of the Dementia Action Plan. The version of the action plan that was last seen by the group was July 2013, which informed a paper to the Healthcare Governance Committee in September 2013.

We were told that the action plan had recently been updated and will be presented to the next meeting of the group. However, the action plan appears to change or remove target dates when actions are not met as opposed to escalating issues or failure to meet targets. For example, the July version states that ‘The Executive team will be trained as Dementia Friends’. This is identified as a high priority and had a target date of October 2013. The January 2014 update had the same action and priority status but had changed the target date to January 2014. Other actions identified as a high priority had no date allocated in the July 2013 version and then simply state ‘ongoing’ in the January 2014 version of the plan. There are 11 discrepancies between the 2 versions of the action plan. This is in addition to a number of actions having no timescale or lead. This meant that governance structures to assess and monitor the quality of service provided to people with dementia was ineffective.

As part of this inspection we considered the management and implementation of the National Institute for Health and Care Excellence (NICE) Quality Standards (QS). We looked at QS1: Dementia and QS30: Quality standard for supporting people to live well with dementia. The Trust does have a policy for monitoring and implementing (NICE) guidance. The Dementia Operational Group, with specific responsibility in its terms of reference to monitor compliance with the quality standards for dementia, had not monitored or reviewed the standards in this financial year.

For example the QS30 was on the agenda on the 29th May 2013 under 'Item 10 – Any other business'. However, this was not discussed and the minutes of this meeting show Item 10 as ‘Dates of Next Meeting’. The meeting of the 28th November 2013 had ‘NICE Action Plan’ on the agenda but the minute states ‘It was agreed that this would be picked up at the next meeting with the correct action plan being circulated to the group.
beforehand.' This meant that QS30 had not been discussed or progressed formally since May 2013.

With regards to QS1, whilst no action plan or minuted discussion was provided, it was confirmed that training in dementia had only recently commenced within the organisation with 24 members of staff having undergone an e-learning package and 24 members of staff had attended a 6-hour training session in December 2013. We were informed that two further 6-hour training events are planned. This meant that the Trust now has an educational plan and anticipates dementia training becoming mandatory, as part of an ongoing revision of the Trust training needs analysis.

Trust does not have a dementia strategy, despite this being a ‘further planned improvement’ detailed in its Quality Accounts. The ‘Quality Accounts’ document provided clearly details that the goals for dementia will be reviewed/monitored by the Healthcare Governance Committee on a quarterly basis and the Dementia Operational Group on a bi-monthly basis. The goals described on page 45 of the Quality Accounts are:

• Further develop the three-year health-economy strategy for dementia care;
• Implement a dementia training strategy; and
• Improve the hospital environment to support dementia-friendly wards.

On page 27 of the Quality Accounts, there is an additional further planned improvement:
• Work with the community groups on the provision of psychiatry liaison service to support dementia care.

From the evidence provided and interviews with the accountable/responsible member of staff, only the hospital environment goal was demonstrated as progressing throughout the year. We did see evidence of this on ward F7 where some improvements had been made. We were told that the wards had obtained a grant to improve the environment for people with dementia.

Senior staff we spoke with confirmed that there was no dementia strategy in place and that whilst the educational plan had been developed; the training implementation only began in December 2013. Some progress has been made regarding the provision of psychiatry liaison services. We were told that from April 2014, a Rapid Assessment, Interface and Discharge (RAID) service will be provided but this is only for patients from the Trafford area as this will be the only commissioned service. Negotiations were on going to ensure that this service would be provided to patients covered by other local authorities.

The Trust had a Clinical Audit Policy that described the process for agreeing the annual forward audit plan and inclusion of priority audits. The audit plan for 2012/13 was met as planned and the plan for 2013/14 is on track. There was limited evidence in the annual report on learning from clinical audit findings and no discussion of monitoring actions arising from audits.

As an example, the lack of routine monitoring of clinical audit actions was demonstrated through the review of the ’Do Not Attempt Cardiopulmonary Resuscitation‘ (DNACPR) audits.

An audit in October 2012 of DNACPR forms had been completed in accordance with the Trust's DNACPR policy. This had highlighted poor completion of the forms and that
improvements were needed. A new DNACPR form was introduced with a revised policy in June 2013. It was also planned for additional training to be introduced but this did not happen due to the absence of a member of staff. There was also confusion within the policy and standards audited. The policy clearly states that 'DNACPR forms must be completed in full. Failure to do this invalidates the order.' The audit, despite highlighting that a small percentage DNACPR forms were completed fully, goes on to state that the majority of patients had a valid DNACPR form. In addition to this, the audit found that just over half of the forms were endorsed by a consultant in accordance with the policy. The policy states ‘Should a specialist trainee initiate or cancel an order, it must be discussed with the Consultant at the earliest opportunity’. The provider may wish to set a specific time scale for this consultation to avoid confusion. This meant that despite the risks to patients being identified by the Trust and recorded on its risk register, monitoring of this area was not apparent and was certainly unsuccessful.

We found that the forms used were confusing and in particular one of the options for review of the DNACPR was 'Indefinite'. This should not be an option and may well be a breach of human rights and in particular the Code of practice for the Mental Capacity Act 2005.

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

The latest published National Reporting and Learning System (NRLS) data places the Trust in the middle 50% of reporters. However, in the wards and departments visited there was clear evidence of under reporting. For example staff on one ward described how patients with dementia were often physically violent towards them and visitors; there were only four incident reports for this ward for physical violence reported from the 1 September 2013 to the 20 January 2014. Ward staff told us that they did not always report incidents where challenging behaviour had occurred as they thought this was the 'norm' and there appeared to be an expectation that staff could put up with this from patients because of their dementia. Staff felt that issues relating to staff shortages were not followed up and an attitude had developed within the staff teams, 'why report when nothing happens'. This meant that mechanisms to report incidents of aggression and violence in relation to patients with dementia and others were not used.

We found that the staff in the A&E department did not routinely report incidents around capacity or service delivery problems. The incident system does not enable the reporter to categorise the incident appropriately. For example, the A&E department was on red alert due to capacity within the Trust on the first day of this inspection; this was reported as 'delayed diagnosis' as there was not a category for capacity. This meant that data in relation to incidents that had resulted in or had the potential to result in harm to service users and others was inaccurate.

We spoke with the Chief Nurse and asked why staff might not be reporting incidents appropriately. One of the potential reasons given was accessibility of the system and the time it takes to report an incident. Staff we spoke with had also mentioned this to the inspectors. We were told that this was to be looked at to find ways of making reporting easier for staff. This person also gave us details of what action had been taken to address the staffing levels on some wards. This meant that senior staff were aware of the problems and were taking action to address the concerns.

We found that the standard of investigation of Serious Untoward Incidents (SUIs) was variable. Not all investigations contained a full root cause analysis. We found that many
planned actions from an investigation were not completed against agreed timescales. This meant that the actions following an investigation could not always minimise the risks to patients and in particular those suffering from dementia.

The new Director of Governance and Risk has acknowledged the required improvements with regards to serious incidents. These were summarised in a report to the Board of Directors on the 19 December 2013 and include the review of root cause analysis training, revised templates for investigations and the monitoring and implementation of actions.

Are the views of people with dementia taken into account?

We found it difficult to confirm if the views of patients living with dementia were taken into account. Care plans and records that we looked at were inconclusive. However the introduction of the ‘Forget me not’ system for patients whilst in hospital and future planned training of staff on dementia may assist to ensure that patients’ views and beliefs are taken into account during their stay in hospital.

The Trust had a ‘Complaints and Feedback Policy’. Quarterly patient experience reports were presented to the Healthcare Governance Committee. These included complaints, Patient Advice and Liaison Service (PALS), NHS choices comments, friends and family test results and survey results. We found that the reports were data rich but did not detail any planned actions to improve patient experience further in response to the analysis. This meant that there was no evidence to suggest that the trust responded to complaints and comments made.

Prior to our inspection we had been made aware of a complaint which had involved a DNACPR issue. We asked to view the file on this complaint. We found that this complaint supported the findings of the Trust's own DNACPR audits. The complainant had found a DNACPR form in their health records whilst an inpatient. The patient had full capacity but this decision had not been discussed with them. The timescale for review was recorded as 'indefinite' and the decision had been made by a specialist trainee without being endorsed by a consultant. This meant that lessons from the audits had not been learned.

The handling of this particular complaint was poor with limited communication to the complainant recorded initially. The complainant was not informed of any anticipated delays and had to contact the Trust to ask why they had not received a response. The response failed to answer the questions the complainant had asked. It should be acknowledged that the complaint was valid and upheld by the Trust and that the Trust recognises that this should have been resolved in a timelier manner.

We did not find any evidence on the patient records we looked at of invalid DNACPR forms. However we were concerned that if this situation could occur with a patient who had full capacity to make a decision about a DNACPR agreement then patients with dementia who may not have such capacity could have invalid forms on their notes. We have asked the provider to take action to address this as a priority.

The Trust has developed an action plan in response to the document ‘A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture, October 2013’ and this was scheduled to go to the Trust Board on the 30th January 2014. A Complaint Review Panel, chaired by a Non-Executive Director, is also being introduced. This meant that trust had implemented processes improve the quality of both the complaint process and response to complainants.
This section is primarily information for the provider

Action we have told the provider to take

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 activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td><strong>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>Management of supply of blood and blood derived products</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>The registered person did not protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.</td>
</tr>
<tr>
<td>Nursing care</td>
<td>Regulation 10 (1) (b) and (2)(C)(i)(ii)</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Termination of pregnancies</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></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 13 May 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.
We are the regulator of health and social care in England.

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

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

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

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

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

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

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

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

You can tell us about your experience of this provider on our website.
How we define our judgements

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

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

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

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

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

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

**Minor impact** - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

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

(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.