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

Royal Hampshire County Hospital

Romsey Road, Winchester, SO22 5DG

Date of Inspections: 21 January 2014  
13 January 2014

Date of Publication: April 2014

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

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<th>Standard</th>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Staffing</td>
<td>✗ Action needed</td>
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<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓ Met this standard</td>
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<th>Registered Provider</th>
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<tr>
<td>Overview of the service</td>
<td>Royal Hampshire County Hospital is a general hospital providing a range of service including emergency care, surgery, diagnostics, paediatrics and maternity. It is located in Winchester, Hampshire, and is one of two acute hospitals provided by Hampshire Hospitals NHS Foundation trust.</td>
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<tr>
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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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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 13 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 reviewed information given to us by the provider. We were accompanied by a specialist advisor.

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

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

What people told us and what we found

This inspection was part of a themed inspection programme specifically looking at the quality of care and treatment provided to support patients living with dementia to maintain their physical and mental health and wellbeing. As the Royal Hampshire County Hospital was non-compliant with staffing at the time of our last visit in January 2013 we also looked at staffing levels on the wards we visited as part of our review of dementia care.

When we visited on 13 January 2014 we went to Bartlett, Freshfield and Mc Gill Wards and the Accident and Emergency Department. We also spoke with some patients on Kemp Welsh Ward. We visited again on 21 January 2014 to review some more records.

When we visited on 13 January 2014, staff were not able to tell us how many patients they were treating within the hospital who had a diagnosis of dementia. However they had records to show that during the previous week, 47 people with this diagnosis were being treated as in-patients. We chose the areas we visited as they were most likely to be supporting patients living with dementia.

Patients that we spoke with were not able to tell us in any detail what they thought about their care and treatment.

We found that systems to assess and plan for the particular needs of patients with
dementia were being developed but had not been consistently embedded into practice. Staff told us that they took the way in which they managed the particular needs of patients who had dementia very seriously and they had already taken a number of steps to improve the quality of care, support and treatment patients with dementia received. This included having specialist nurses skilled in dementia care. Training was available to improve staff practice and staff understanding of the experiences and the needs of people with dementia. There were also systematic audit processes to monitor progress in how the trust was achieving its aims to improve the experiences of patients with dementia in hospital.

More staff posts had been filled since our last visit and the trust had systems in place to ensure that staff were deployed in the most effective way possible. We found however that particularly Freshfield ward and at times Bartlett ward continued to be under staffed. This meant that patients with dementia on these wards were at risk of not having their needs met.

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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#### Our judgement

The provider was not meeting this standard.

While staff mainly provided care and support in a sensitive way, there was not an effective system in place to ensure that the needs of people with dementia were consistently identified, assessed and planned for.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

#### Reasons for our judgement

**How are the needs of patients with dementia assessed?**

We looked at eight care and treatment records for patients on Freshfield, Mc Gill and Bartlett wards. We also spoke with staff on these wards and staff in the Accident and Emergency Department. Eight staff also provided us with written feedback. We observed care that was being provided in Freshfield, Mc Gill and Bartlett wards and spoke to patients when we could.

Staff working in the Accident and Emergency Department told us that the hospital was working to develop a standardised assessment tool to identify patients who had dementia. This had not yet been implemented. This meant that there was a risk that the needs of patients with dementia might not be identified and acted upon to keep them safe. We saw two assessment documents which were being used on the wards, both of which were being used on the day of our visit and both of which assessed patients' needs. The 'multi-disciplinary record of admission' contained an abbreviated mental test score which was intended to be completed for all patients over 65. The 'patient information record' contained an admission section which had space to record a diagnosis and other information such as whether the patient was vulnerable, confused elderly, confused due to a physical condition or confused due to medical treatment. There was also space on this form to record if a patient needed help to communicate. The patient information record contained a nursing assessment which prompted staff to ask for information about any communication needs and included a short test of cognition and depression. Where a patient's cognitive state was in doubt staff were instructed to investigate the cause of confusion and check if the person was known to the mental health services.

Patient's assessment records on wards that we looked at had not always been fully
completed. For example, the records showed the test for cognition was sometimes blank. This meant that patients who may have had impaired cognition due to possible dementia were not clearly identified.

In one record we saw a family member had been asked to complete an assessment about the patient's interests and history and what was important to them. This helped staff to understand how to communicate with them more effectively.

The initial nursing assessment carried out when patients were admitted did not help staff to understand how to assess pain in patients with dementia. Staff we spoke with told us that they would assess patients who could not tell them that they were in pain by looking at their body language and facial expressions. Staff told us that they could use the 'Abbey pain score' to assess patient's pain. The Abbey pain scale is a recognised tool for measuring pain in people with dementia who cannot verbalise their feelings. However staff said that this was not consistently used and records we saw confirmed this. For example, one patient's record showed they were receiving morphine for pain relief and there was no assessment in place for pain management. This meant patient's with dementia were at risk of not receiving pain control in a consistent way to meet their needs.

How is the care of patients with dementia planned?

Patient records that we saw contained no specific plans to meet their cognitive care and support needs whilst they were in hospital. Care planning focussed instead on patient's specific healthcare needs. Patients with dementia whose records we reviewed had complex needs, including behaviour which challenged and communication difficulties. Guidance about how these particular issues should be managed was very limited. For example, one care record showed the patient "attempted to bite." However there was no care plan in place to reflect how this should be managed by staff.

We looked in detail at care planning for patient's who had a diagnosis of dementia in Freshfield ward. Although there was a lack of written care planning, regular reviews of patients needs took place. This included a daily review with medical, nursing and social care staff, to discuss the on-going needs of each patient. Outcomes were recorded in notes, which were written in one place, so that all disciplines could contribute to the evaluation of care.

Staff told us that the dementia specialist nurse was also very supportive in helping staff to plan patients care and support.

We spoke with staff who showed us documents called 'This is Me'. These were specifically related to patients with dementia and included information about their needs, preferences and interests. We did not see that any of these documents had been completed whilst patients had been in hospital.

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

We spoke with 12 patients with dementia most of whom were unable to give us feedback about whether they were involved in making decisions about their care. One patient said "I suppose I can discuss my treatment, but my daughter does all that." We spoke with two visiting relatives. One said "I am very proactive. When mum came in I told staff about her diet". Another relative said "Staff don't tell you about the treatment, you have to ask". We observed that most staff explained the care and treatment they were giving to patients and they asked for their consent before and during the delivery of care. This provided evidence that patients were asked about decisions relating to their daily care and support.
We asked what happened when patients with dementia lacked capacity to consent to their care and treatment and when they resisted the care and treatment needed to maintain their health or to keep them safe. A senior member of staff told us that there been one deprivation of liberty issued in respect of a patient who had dementia 'in a very long time'. The Deprivation of Liberty Safeguards (DOLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a hospital only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. When a Deprivation of liberty application had been made we saw that appropriate processes had been followed.

Whilst we were visiting Freshfield ward, a patient came past with a bag and was making for the door. Staff said that this patient often wanted to 'go home'. One member of staff said that another patient had recently got out of the ward and had been brought back by staff. We could not see evidence that this had been considered in terms of being a possible deprivation of the patients’ liberty. As a deprivation of liberty application had not been considered for this patient staff could not demonstrate that they were being treated and cared for after in a way that did not inappropriately restrict their freedom. We saw no evidence in records seen that an assessment had been made regarding a patient’s mental capacity to consent to treatment and care. Nor was there evidence of best interest assessments, although it was apparent that this was undertaken informally in consultation with families and other health and social care professionals.

We saw that some files recorded the decision not to resuscitate the patient in the event that they experienced a cardiopulmonary or respiratory arrest. These were individual, clinical decisions, based on risk and we saw they had been made following consultation with relatives and taken in the best interest of the patient.

Are patients with dementia provided with information about their care?

During the visit we observed that patients were provided with information that they could understand about their care, such as staff explaining what they were doing as they provided support. There were also posters and leaflets on the wards to provide advice and guidance to patients and their families. On daily recording notes it was evident that where a patient was unable to understand information, time had been taken to consult with family members. Staff told us that communicating with relatives of patients with dementia was an area that they were keen to improve upon. We saw in one patient's records there was a copy of a letter from the dementia care nurse to relatives of patients with diagnosis of dementia inviting them to discuss care and treatment options. A visitor confirmed that they had been provided with information about their relatives care and said that staff had been "Very kind and helpful." They had also spoken with a doctor about the discharge plan for their relative.

How is care delivered to patients with dementia?

Wards we visited were separated into bays. On Mc Gill ward there was a desk on each bay for staff. Although this had not been put into place to specifically address the needs of patients with dementia it meant that staff could monitor patients closely and could respond to them quickly. This was especially important when patients were unable to use their call
bell to request assistance. Staff on this ward said the number of patient falls had decreased since this system had been implemented. McGill ward had a system of 'triage' where patients were assessed and allocated to beds. Again, staff said that this was not specifically designed to meet the needs of patients with dementia, but the process helped in identifying patients who had this condition.

The framework for staff training was graduated depending on staff roles and responsibilities and the extent to which they were likely to come into contact with people with dementia.

Training in 2013 had prioritised staff on long term condition wards. Approximately 375 staff had attended a City and Guilds one day course in dementia awareness and another 30 staff were booked onto this course. All health care assistants, domestic and support staff were expected to attend this training.

Dementia ward champion training had taken place to assist key staff to start implementing good practice initiatives to improve patients with dementia's experience of care. This included teaching staff about "This is me" documents and the "Sunflower scheme" on their wards. "This is me" is a simple and practical tool that people with dementia or their carers can use to tell staff about their needs, preferences, likes, dislikes and interests. The sunflower scheme uses an image of a sunflower above a patient's bed to alert staff that they may need extra help. We observed that a sunflower was displayed over some, but not all beds occupied by patients with dementia on Freshfield ward.

According to their Dementia Training plan for 2014, the trust was aiming to deliver basic training in dementia awareness at induction to all health care assistants and to all volunteers. This included information about how to communicate with patients with dementia and how to support them with food. We asked staff on the wards we visited about what training they had received to support patients with dementia. Most staff said that they had completed the dementia awareness course and said that they had also received some training on the ward which had been delivered by the specialist dementia nurse. This included looking at the needs of particular patients and seeking specialist advice about their care and support. On Freshfield Ward specific training had been provided to staff about how to manage the needs of patients with dementia who may have behaviour which challenges and on the safer moving of confused patients.

Patients we spoke with were unable to tell us in any detail what they thought about their care and treatment. Those that were able to, said they were well looked after. We used our SOFI tool to observe how care was being delivered to patients with dementia on Freshfield ward. There was evidence that staff were alert and responded to patient's nutritional needs. We observed that one member of staff was supporting patient's to drink milkshakes and was giving patient's supplements and snacks. One member of care staff was heard reporting to nursing staff that a patient was having swallowing difficulties when they were eating their lunch. The member of staff asked for guidance about what to do to assist the patient to eat their meal safely. Another patient, who according to their records was at risk of choking, was being assisted to eat part of their meal by a volunteer. Although volunteers had received some training in supporting people to eat, we were told by nursing staff that volunteers should not be supporting people who had a problem with swallowing. Records showed that one patient on Mc Gill ward had been refusing their meals and the records of their fluid intake indicated that they had not received adequate amounts to drink. During our visit this patient was asleep in the morning and a staff member confirmed that they had not had breakfast when we checked at 11:25. Staff said that generally patients who needed specific support with their nutrition would be referred to a dietician, but this had not happened as yet with this particular patient. This put the patient at risk of not having...
adequate support to meet their nutritional needs.
We saw that staff worked hard to be available to patients when they were needed, however we saw that this was not always possible as at times they had to react to situations, such as providing support to other patients with dementia who were distressed.

On Bartlett ward we saw two patients who were confused and disoriented and whilst we saw staff tried to support them, they were sometimes busy with other patients. On one of these patient’s records it showed that at times they were ”Confused and disoriented” and that they had sometimes ”Refused care”. There was no plan to indicate how staff should manage this to assure that this patient’s emotional needs were met.

Is the privacy and dignity of patients with dementia respected?

We saw that staff mainly provided dignified care and treated patients with respect even in situations which were challenging to manage. One staff was providing one to one support to a patient who was disorientated and agitated. The staff member was seen to provide care in a sensitive manner.
Staff communicated with patients in a respectful way, calling them by their preferred name and providing calm and reassuring care. We saw all the beds had privacy curtains that the staff used when providing care. A staff member told us they used the red codes on the curtains which alerted other staff they were providing care. We observed medical staff also drew the curtains when they were assessing patients. A relative said there ”Was no problem with dignity as they (the staff) always pulled the curtains.”

On one of the wards we saw a patient was sat out in their nightdress which was short and may have compromised their dignity. A staff member told us this patient should have been ’looked at’ when they were supported to get out of bed. We observed that a patient was distressed as they had chosen a bar of chocolate from the mobile shop but had to return it as they did not have any money. This led to them having increased anxiety about what money they had. We raised this with the ward sister who told us they would look into whether the person could have some money available to them.
All the wards we visited had single sex bays and staff told us they always tried to ensure they adhered to this. All staff we spoke with showed an awareness of protecting patient's privacy and dignity and the need to treat people with respect. A senior member of staff told us the trust had policies on maintaining privacy and dignity and followed the National Institute for health and Care Excellence(NICE) guidance. This showed that staff were aware of national guidance to help them to understand and meet patients' needs.
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 cooperation with others.

Reasons for our judgement

Do providers work together when providing care to patients with dementia?

We found some evidence that hospital staff worked with medical and care staff in the community to ensure that patients with dementia received the care and support that they needed. For example, one patient's record showed they had been admitted straight to the ward following referral from the General Practitioner. This avoided the need to go through the Accident and Emergency department, which may have caused the patient unnecessary distress.

Staff told us that although they could not access records directly which were held by community mental health services, they contacted them where necessary. This helped to establish whether patients were already known to mental health services and helped to inform their care and treatment whilst they were in hospital.

The hospital was promoting the use of the "This is me" form. Evidence was mixed about how often this form was actually being used. We checked two patient's records who had been admitted from local care homes to Freshfield Ward. No information had been provided when they had been admitted. Staff said that when patients were admitted as an emergency this was particularly an issue. When this happened the hospital staff telephoned the care home for clarification. Staff said that lack of information could at times cause confusion; for example, sometimes staff might not be calling patients by their preferred name. Staff said that when patients did come in with a "This is me" form it helped to ensure that hospital staff provided appropriate care and support.

A discharge summary was completed when the patient was leaving hospital. If the patient was going into a care home a copy was sent to the home along with a transfer letter. A copy of this documentation was also sent to the patient's General Practitioner. This ensured that appropriate information was shared so that patients, once discharged could continue with their treatment.

We looked at records for a previous patient who had been subject to a Deprivation of Liberty Safeguard (DOLS). This had been issued because this patient had continually
wanted to leave the hospital to return to their home and they had been assessed as not having the capacity to make this decision because of their dementia. Staff said that when an application for a DOLS was made, the trust staff worked cooperatively with staff from adult social services who undertook the DOLS assessment. They felt that this process worked well. We looked at the discharge summary for this patient who was leaving to go to a care home. The provider may wish to note that this did not mention that they had been subject to a DOLS whilst at the hospital. This is important information that could affect the planning and delivery of the patient's future care. Staff said that normally this information would be recorded on the discharge summary and that it would also have been conveyed verbally.

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

We saw evidence that the trust had taken some action to ensure that patients with dementia obtained appropriate health and social care support. There was a dementia clinical specialist nurse who provided liaison to care in the community services and advice and support to ward staff about patients mental health needs. They also provided some teaching. The dementia clinical specialist nurse was working with occupational therapists and speech and language therapists to organise and deliver training on safer moving of confused patients and communication and swallowing difficulties of patients with dementia. We were told that there was a plan to increase the number of dementia clinical specialist support hours available. Wards also had dementia champions who could also provide staff with additional support and guidance.

There was a multi-disciplinary approach in the hospital, with health and social care professionals working together to plan patients care. We looked at care records to assess how other care professionals were involved in patients care and treatment. We also spoke to a dietician who confirmed referrals were made to them to assess patients who were at risk of malnutrition to ensure that they received appropriate care and support. Staff on Freshfield said that the absence of a dedicated social worker based on the ward had made this more difficult to achieve. Staff told us that they worked hard to ensure that patients were referred to the most appropriate specialist support and gave examples of when they would refer patients to the older people psychiatry team or to adult mental health services.
**Staffing**

There should be enough members of staff to keep people safe and meet their health and welfare needs

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**Our judgement**

The provider was not meeting this standard.

Improvements had been made to staffing levels. However, there remained, at times insufficient staff to meet the needs of people with dementia on Freshfield and Bartlett Wards.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

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**Reasons for our judgement**

At our last inspection in January 2013 we found that there was not enough qualified, skilled and experienced staff to meet patients’ needs. This appeared to be particularly the case in the medical wards. We judged this to have a minor impact upon people and we told the trust to take action to address the shortfalls identified.

The trust responded with an action plan which detailed how they were going to achieve compliance. This included a review and increase of staffing levels in line with the hospitals workforce development plan, greater attention to be paid to recruitment processes and further training to be provided to volunteers to support and develop their role.

As part of this inspection the trust provided documentation to support the further improvements that had been made in terms of staffing levels. This included a nursing budget comparison for 2012-13 and 2013-14. This demonstrated that the budget for staff had increased in the current year 2013-14 across nearly all disciplines. The hospital used a safer nursing care tool. The Safer Nursing Care Tool is one method that can be used to assist Chief Nurses to determine optimal nurse staffing levels for in-patient wards. There was guidance for senior staff about action to take when a staffing shortage had been identified and we were told that this was being followed.

When we visited we looked at staffing levels in the Accident and Emergency department and on the wards that we had chosen to focus on for our review of dementia care. The remaining part of this report therefore reflects the evidence we gathered when we visited the Accident and Emergency department, Bartlett, Freshfield and Mc Gill Wards.

We found during our visit that some improvements had been made. For example, the Accident and Emergency Department had created a non-clinical post for a general assistant. This reduced the pressure on nurses and health care assistants in this area. Staff working in the Accident and Emergency Department said that staffing levels had generally improved. The trust was actively recruiting to fill the one current vacancy.

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were told by people working in this department that when they were short staffed, they were often supported by staff seconded from wards.

We spoke with patients, visitors and staff. Eight staff also provided written feedback. Patients and visitors we spoke with did not comment on staffing levels. The trust provided written information regarding staffing levels for a period of two weeks on wards.

Staff on Bartlett ward told us that there were not always enough staff to support people with dementia. One staff member explained that it could take longer to support people with dementia who could become anxious or confused. We witnessed one patient who needed almost constant reassurance and another who had become distressed over a particular situation. We observed that staff provided a high level of support to the patient who required constant reassurance but that when they stopped doing so the patient quickly appeared worried and distressed again. Staff said dementia volunteers helped enormously when they were available as they were able to spend more time with the patient reassuring and comforting them.

The trust supplied information regarding staffing levels on Bartlett ward for two recent weeks. Planned patient numbers were 27. Actual patient numbers varied between 24 and 31. Planned staff ratios in the morning was one staff to three patients. Five times over this two week period there was one staff to four patients. The afternoon shift was allocated one staff to five patients and nine times the ratio was better than this. Similarly night time shifts either met their planned ratio of one staff to seven patients or exceeded this. Where there were shortfalls in the morning, extra staff were on duty later in the day.

We spoke with five staff in Freshfield ward who said the trust had recruited to vacant posts in the ward but that it was still often understaffed. Staff said that although care was carried out the staffing shortfalls had some impact on patient care. For example, one staff told us at 3:30 pm on the day of our visit that they had not yet had time to complete the daily records for the nine patients that they were responsible for during the shift. They also said that one patient had not received their personal care until after lunch as they had been ‘very busy’. Staff said that patients received "The care that they immediately need, rather than the time and care that patients with dementia may require". One senior member of staff told us that there was not always sufficient time to review in depth patient's needs with all staff involved in their care and support. Staff said that the loss of a social worker based on the ward had adversely affected multi-disciplinary care pathways from hospital to community.

We used our SOFI tool to observe lunch on this ward. We saw a member of staff cut up a patient’s food for them, encouraged them to eat and left them. The patient stopped eating. Two other members of staff came in and spoke to the patient at different times. There was no continuity of support for this patient during this time, who appeared distracted and was fidgeting. After a total of forty minutes we saw that the food tray had been removed. It was unclear how much food this patient had eaten.

The records of one patient showed that they had taken a very limited fluid intake over a number of days and a limited diet, with no lunch or supper recorded on one day. As the records did not include food or fluids offered it was not possible to evidence that patients were being offered sufficient food and drinks. We were told by three members of care staff that they felt that they often "Did not have time to fill in the records at the time”.

The trust supplied information regarding staffing levels for two preceding weeks on Freshfield ward. Planned patient numbers for this ward was 26. Actual numbers varied
between 20 and 27. The planned ratios for morning shifts was one staff to three patients. Six times during these two weeks the ratio was one to four. In the afternoons the planned ratios were one staff to three patients. For ten shifts out of 14 they were short staffed with one staff to four patients and on three shifts they were one staff to five patients. At night the planned ratio was one staff to seven patients. Staff numbers were generally better than this with the exception of one night when staffing ratios dropped to one staff to ten patients. This showed that the ward was often operating with fewer staff than planned.

Staff on Mc Gill ward mostly felt that there were sufficient staff on duty to meet patients needs. The ward had been organised so that a staff desk had been placed in every bay. Staff we spoke with said that this had resulted in a decrease in falls and fewer complaints. When we visited we observed that staff were present in all bays and that they provided prompt attention to patients. We observed that they were able to respond quickly to patients who needed assistance who were unable to call out or alert them in other ways.
### Assessing and monitoring the quality of service provision

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

#### Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

#### Reasons for our judgement

How is the quality of dementia care monitored?

There were a number of audits in place to monitor the quality of care for patients who had dementia. Recent audits we saw looked at how the nutritional needs of patients with dementia were being managed. There was an audit which looked at whether patients with dementia received a nutritional risk assessment and whether they received the support they required during mealtimes. This audit took place across the trust but included wards likely to have a greater proportion of patients with dementia such as those we visited. Results showed that the nutritional tool had been completed in 91% of cases and 98% of patients had been provided with appropriate assistance. The provider may wish to note that on the day of our visit a patient on Freshfield ward had not been provided with appropriate assistance with their meal. Other audits were undertaken to provide assurance that mealtimes were protected and that appropriately skilled staff were available to assist dementia patients who had dysphasia during mealtimes. Dysphasia is a partial or complete impairment of the ability to communicate. This again was across the trust. This audit established that in some wards there were no staff trained in dysphasia. We saw that a further audit was planned for March 2014 to establish if more staff had completed the available training. The provider may wish to note that when we visited we observed The quality of the environment had been monitored in relation to patients with dementia. For example, on Freshfield ward there was clear signage, with pictures as well as names on doors, to assist patients with either sensory or cognitive difficulties.

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

The trust used a system called Datix to record, monitor and communicate adverse incidents in the hospital such as falls. The system was not able to identify whether patients with dementia were subject to more near misses or adverse incidents than other patients who did not have dementia. We discussed this with senior staff at the time of our visit who said that they would investigate further if this information could be captured by the Datix system. Assessments had been completed regarding patient’s specific health risks such as if they
were at risk of becoming malnourished, those who were at risk of developing a pressure ulcer, and patients who were at high risk of falls. Some preventative action had been taken if patients had been identified as being at high risk in a particular aspect of their care, such as a pressure alarm mat had been put in place for one patient who was at risk of falling to alert staff when they got out of bed.

We observed that staff checked patients' well-being regularly. This is called 'intentional rounding'. 'Intentional rounding' involves health professionals carrying out regular checks with individual patients at set intervals. We saw that this included checking to ensure that they had a drink and had been assisted to change position to relieve pressure on skin integrity.

Are the views of patients with dementia taken into account?

We saw good evidence that the views and experiences of patients with dementia had been incorporated into training for staff. Although this training had not started at the time of our visit, the training plan for 2014 included a presentation to be given by a man who had been diagnosed with dementia. The presentation was about his life and his journey up until and after his diagnosis. The wife of a patient at The Royal Hampshire Hospital was also going to provide a teaching session on dementia care and compassion.
### 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 activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider must ensure that each service user is protected against the risk of receiving care or treatment that is inappropriate by means of carrying out an assessment of their needs and planning and delivering their care in a way that meets their individual needs. Regulation 9 1(a) (b) (i)</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Staffing</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>There was not enough qualified, skilled and experienced staff to meet patients' needs. Regulation 22.</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
This section is primarily information for the provider

report on our judgements.
About CQC inspections

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

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th><strong>Met this standard</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action needed</strong></td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td><strong>Enforcement action taken</strong></td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
</tr>
</tbody>
</table>
How we define our judgements (continued)

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

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

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

- 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.
<table>
<thead>
<tr>
<th><strong>Glossary of terms we use in this report (continued)</strong></th>
</tr>
</thead>
</table>

**(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.