# Dignity and nutrition for older people

## Review of compliance

| **St Helens and Knowsley Teaching Hospitals NHS Trust**<br>**Whiston Hospital** | |
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| **Region:** | North West |
| **Location address:** | Warrington Road,<br>Prescot<br>Merseyside<br>L35 5DR |
| **Type of service:** | Acute Services |
| **Publication date:** | June 2011 |
| **Overview of the service:** | St Helens and Knowsley Teaching Hospitals NHS Trust is a large acute hospital registered with the Care Quality Commission to provide a number of regulated activities. The organisation provides acute healthcare to large area that covers three Local Authorities. The area is |

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| | largely urban but some rural areas are also covered. The trust provides acute hospital services to the residents of the Merseyside area. |

# Summary of our findings
for the essential standards of quality and safety

## What we found overall

**We found that Whiston Hospital was not meeting one of the essential standards we reviewed. Improvements were needed.**

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

## Why we carried out this review

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

## How we carried out this review

The inspection teams were led by CQC inspectors joined by a practising, experienced nurse. The inspection team also included an 'expert by experience', this is a person who has experience of using services (either first hand or as a carer) and who can provide the people perspective. We visited ward 5A and 5B within the hospital both supporting elder people with medical needs on 28 March 2011.

We reviewed all the information we held about this provider and carried out a visit. We observed how people were being cared for and how the staff interacted with people staying in Whiston Hospital. We spoke with ten people staying in the hospital and five carers visiting. Comments are included within the report from both the people staying in Whiston Hospital and their relatives. Twenty staff who worked in Whiston Hospital were both formally and informally interviewed and their comments are included within this report. We checked the provider's records including policies procedures and survey results. We also looked at ten peoples care records with their permission.

## What people told us-

People told us that staff responded quickly to call bells, this was confirmed by relatives. There was a mixed picture of how people felt their views were listened to with some people telling us that staff did not take the time to discuss their care needs, whilst other people reported that they did feel that communication helped them understand how their needs were to be met.

The majority of people told us that their dignity needs were met, with staff making sure that they "knocked on doors" and "closed curtains", as needed. There were positive comments made about the staff including "lovely", "kind" and "caring". Our observations during our visit showed that the majority of staff interacted well with the people they were supporting.

People staying in Whiston Hospital told us that they generally found that the food was "tasty". The majority of people told us that they "were asked what they wanted each day" and "there is a lot of choice". People less able to make a choice or needing a soft diet reported that the food offered could be very repetitive. During our visit we noticed that soft diets were not always well presented.

Of the two wards (5A and 5B) that we looked at, the experiences of people on one of the wards was more positive than the other. A number of initiatives had been put into place on one of the wards that had impacted on the quality of staff members' understanding and support to people with their individual nutritional needs.

Wider information relating to dignity and nutrition is available with the report below.

## What we found about the standards we reviewed and how well Whiston Hospital was meeting them

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

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

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

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

## Action we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

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

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

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

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

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

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

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

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

# Outcome 1:
# Respecting and involving people who use services

## What the outcome says

This is what people who use services should expect.

People who use services:

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

## What we found

**Our judgement**

**There are minor concerns**

with outcome 1: Respecting and involving people who use services

**Our findings**

**What people who use the service experienced and told us**
During the visit we observed that staff generally spoke to people in a supportive manner. Staff members were respectful, although the conversation was often of short duration. A staff member was heard to shout, "can you help feed number three". This exchange was not in keeping with respecting people as individuals. Staff generally presented as friendly, patient and caring. They advised people of what they were doing in advance of undertaking any activities. People spoken with told us that staff did respect their dignity and reported that they felt well supported by the staff. Comments such as "lovely", "kind" and "caring" were regularly used to describe the staff.

We observed that a high level of people (approximately half) did not have their own clothes and were wearing hospital-issue gowns/ pyjamas. We were told by ward staff that care homes/family carers did not supply personal clothing, toiletries and some people did not have their own slippers. The hospital staff told us that they were unclear what action they could take.

We saw that staff drew curtains round people before carrying out examinations or personal care. When staff members were talking with people, they spoke quietly to maintain privacy. People told us that staff addressed them by their first names. They also told us that although they "did not mind" this, their preferred name had not been discussed with them.

Call bells were available but were not within reach of two people and another person did not have a call bell available at all. We noted that staff did check on people during the day who were unable to use a call bell to summon help. When call bells rang staff answered them promptly and this helped limit any noise and helped staff respond to people's needs. People we spoke with told us that staff, "answer the bell very quickly". This was agreed with by relatives who also told us that they thought staff attended quickly to help people with their needs.

We were given mixed views about how well people's relatives were consulted with. Some people told us that they had received a lot of information about the care needs of their relative. One relative told us that staff had explained the actions needed for their relative and had discussed choices and options as to the best support. Another relative told us that they had received very limited information and were unsure of the treatment or support staff members were delivering. The person had received conflicting information about what they could and could not do to support their relative and became unsure as to what was acceptable.

People also said that staff members maintained their privacy and dignity by having single sex accommodation and using curtains and knocking on doors of single rooms before entering and using a private room for consultations about sensitive matters. The wards we visited are part of a newly built hospital. The majority of beds are single bedrooms with four rooms of four beds. The four bed/bay rooms were large enough to accommodate a dining table and people were asked during the day on one ward if they preferred to eat at the table.

**Other evidence**
We looked information that we held about the service. This information told us that in 2009 Patient Environment Action Team (PEAT) had rated the Trust as ‘much better than expected’ for modest, dignity and respect. Overall PEAT data rated Whiston Hospital as "Excellent". There were no results available for 2010. Other information within our own showed that the Trust performed ‘about the same’ as it had preciously in the latest adult inpatient survey (2009).) People reported that they were treated with respect and dignity whilst they were in hospital.

We looked at how staff involved people in making decisions. All said that they would explain about the care planned and ask for permission to carry out any care. Staff members demonstrated in discussion that they were aware of ways to explain to people their treatment and to obtain relevant consent. Staff told us that they did not have a lot of experience of using independent advocates. They identified some training needs in helping them assess capacity and making decisions in the best interests of people.
Some staff said that they had received training and understood what was required of them to safeguard people’s rights.

Senior management told us that patient passports are not yet in place. Information from the Trust told us that they intend to fully implement the patient passport system which supports staff to have a fuller picture of people's needs. A manager told us that some people will bring in their patient-held (own) records, but said that the nursing staff did not really look at them. When we looked through records for people admitted from a care home we were unable to locate the transfer information from the care home. Staff confirmed that they usually received this but the information in them was not always easily transferred to the hospital's own records.

Most ward staff had received some training in understanding and implementing individual privacy, dignity, independence and human rights. All staff told us that they thought that people's privacy and dignity was well maintained. Senior staff told us that they were working to assist staff to develop their awareness and competence in supporting vulnerable older people.

Records reviewed identified people's faith and cultural diversity. Of the records we viewed there was limited information as to what this means for the individual's care. Records reviewed provided limited detail of individual choices or preferences. All the records we viewed had assessments in place that identified if people were at risk of the development of pressure ulcers, falls or poor nutrition. We were unable to locate what actions were being taken from some people assessed at high risk. Staff told us that a full discussion at "handover" took place each day to make sure that all staff members were aware of people's needs.

Staff told us that there is a dignity champion available for each ward and a meal co-ordinator who helps people choose their meals. Staff told us that the dignity champions have not yet progressed into specific programmes and the Dignity in Care Steering group has been disbanded. Senior management informed us that they are currently trying to recruit additional dignity champions in order to further expand the programme and create dignity at "the core" of the service.

Interpreting support is provided for people whose first language is not English. Senior management told us that family members are provided with contact numbers of matron, ward manager and ward. Family members also are provided with copies of case conference notes. There was limited written information provided to people to help them understand what they can expect/standards. There is a short leaflet 'Information for Discharge' that deals with medication/follow up visits. Staff told us that there are listening clinics in place two evenings a week for people to drop in and raise any concerns.

Staff said that there is a monthly survey available and this is a bit "hit and miss" as it's not always given out or completed. A copy of the survey was shown to us and this asked straight forward questions. There were no readily available copies of this on the wards we visited. People spoken with did not recall seeing this nor did their families. Some staff members said that they were not aware of any formal ways to give feedback to gather views but there were external audits in place.

The trust has implemented a programme known as "forget me not". This is a voluntary programme that outlines people's basic needs such as who their relatives are, what they like to eat or drink. In discussion with senior management we were

informed that this has recently been introduced to one of the wards. There is an intention to roll this out to further wards. Staff told us that they particularly liked the "forget me not" and found it very useful. Managers informed us that the "forget me not" is an extensive programme and is not just reliant on some personal details. It can and will be used to help identify people with a degree of cognitive impairment as they move around the hospital. It aims to discreetly inform staff that the person may need extra time and support. The Trust had undertaken this programme as a direct result of listening to people.

**Our judgement**
People staying in Whiston Hospital have their privacy, dignity and independence respected. Individual views and experiences are not always explored or recorded sufficiently for them to be taken into account in the way the service is provided and delivered.

# Outcome 5:
# Meeting nutritional needs

## What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

## What we found

**Our judgement**

**There are moderate concerns**

with outcome 5: Meeting nutritional needs

**Our findings**

**What people who use the service experienced and told us**

We looked around the wards to see what information was available for staff and people regarding choices of food. There was some information about people's choices in the "forget me not" programme. This was brief but was very useful. A chart in the pantry/kitchen did outline some specific needs such as red tray or red jug arrangements. Red trays and jugs are used to identify people who may need extra support with food and drink. Menu cards were given to people daily and recorded what a person had ordered. These were not collated in order to make sure that the person had received what they had ordered or that they had received a varied diet suitable to their needs. Comments from people included "plenty of choice", "choices can be a bit similar", and "someone asks me everyday what I would like to eat". We saw that on one ward red trays and red jugs were in use. There was a checklist in the pantry area of people identified as requiring red trays. This was an accurate reflection of needs. On another ward only two red trays were used despite staff reporting and the CQC team observing that almost half the people needed some form of assistance.

Relatives visiting on both wards told us that they were happy to continue to provide support to their relatives with eating and drinking. One person told us they felt that their involvement was valued by staff as their relative was reluctant to accept food from others. The person commented that their relative was, "offered practically the same food every mealtime". Another person told us that they had filled out the

"forget me not" sheet but generally nobody had spoken to them about what they like to eat. They did not like white bread but were not asked what their preference was and all sandwiches were made with white bread. A staff member later told them that brown bread was available but this needed to be specifically requested. The same person also commented that there appeared to be a lack of fresh fruit.

During our visit we observed that people were not offered an opportunity to freshen up prior to being served a meal. People spoken with said that they were "sometimes" offered the chance to wash their hands before they received a meal. We saw staff encourage people in the larger bays on one ward to eat their meals at a table if they were well enough. Lounge areas were not used for people to eat in and remained unused throughout our visit. On another ward people were not encouraged to sit at a table. It is good practice to make meals a more social event and support people to eat their meals in a manner that appears more in-keeping with their normal routine.

On one ward we observed that people were helped to sit out of bed or sit up if needed. On another ward this did not happen to the same level. On one ward two people out of four had their food whilst they were lying down and attempted to feed themselves. Staff did not offer to sit them up or assist them. One person reached out and spilled the soup left on their table, over their bedding and clothing. Staff did attend immediately to change both the bed and the person.

On one ward we saw that staff members were available to assist people as their meals were placed in front of them resulting in the majority of people receiving appropriate and timely assistance. On another ward we saw that this good practice was not in place. One person's meal was delivered and a member of staff promptly helped them to eat it. However, another person in the same bay had their meal delivered at the same time. The person did not have any assistance and the food was left on their table for over half an hour before they were assisted to eat. Some people struggled to remove the tops of pots such as trifle, yoghurts and staff did not attend to assist or remove the lids. We observed that although the mealtime was in place and staff members were needed to assist several were occupied with assisting in doctors' rounds, giving out medicines and dealing with laundry returning. The Trust told us that it intends to implement protected mealtimes which will mean that other activities will not take place at mealtimes.

On both the wards all courses were served at once. As a good choice of food was available this could be soup, main course and a hot or cold sweet. In general people do not eat all their courses at once. We discussed this with the senior management who agreed that this issue would be addressed promptly. We observed people who missed a meal because they did not like the food that they were served or had no appetite. We checked the records after the lunch and all had been recorded as "refused" their meal but there was no record that an alternative had been offered.

Some of the food did not look appetising. Soft diets appeared particularly unappealing as they tended to dry out at the edges. When asked staff was not sure what food the soft diet was. Although soft diets came with each item such as potatoes, meat and carrots placed separately on the plates several staff members mixed this altogether to feed people, making the meal look less appetising. On one

ward staff sat down next to the people that they were helping to eat maintaining eye contact and allowing people time to eat. On another ward staff stood over people to help them to eat.

**Other evidence**
We looked at the information that we held about the service. This information told us that in 2009 Patient Environment Action Team (PEAT) had rated the Trust as 'much better than expected' for nutrition. Overall PEAT data rated Whiston Hospital as "Excellent". There were no results available for 2010. Other information within our own showed that the Trust performed 'about the same' as it had preciously in the latest adult inpatient survey (2009).) People reported that they did receive ta diet hat met their needs when they were in hospital.

The Trust told us that they "plan to fully implementing their nutritional initiatives on all wards by October 2011, review nutritional support equipment by end of April 2011 and continue to undertake nutritional audits monthly as part of the Nutritional Steering group initiatives. The Trust took its responsibilities seriously and the majority of people had found their nutritional needs had been met".

There is a Nutritional Steering Group that meets monthly to look at nutritional issues. Trials of specific actions have taken place on two wards, one of which we looked at on the day of our visit. We were able to evidence that the initiatives put into place were starting to have a positive impact on the ward we visited. Staff reported a significant decrease in complaints about food since the initiatives had started. A senior manager told us, "there is a huge challenge ahead to raise awareness and re-educate staff. Structured mealtimes are not yet in place but the Trust is rolling out improvements for the future. We need to raise the profile of food and fluids".

We were able to identify people who needed thickened fluids due to swallowing difficulties but were unable to find any records that showed that they had received a swallowing assessment or at what thickness their fluids needed to be. Risk assessments for nutritional needs were in place and they did identify were people needed a special diet such as thickened fluids or soft diet. The actions to be taken by staff to support people with special diets were not recorded within the records in the hospital including risk assessments. Risk assessments identified the risk but not what action was needed to reduce the potential risk.

Some dietary supplements were in use but the records available did not reflect what they were in use for or which ones were to be used. We had received a copy of a letter from the Ombudsman. The letter stated that in a recent complaint submitted to them they found that "despite the patient being prescribed nutritional supplements the nurses had failed to ensure that they took them. In addition there had not been a discussion with the patient or their family to establish why they had not talked to them to establish a nutritional plan".

The Trust has put into place records that are meant to record what food or fluids a person has had. Where a risk was identified people did have a food and fluid charts in place. We found staff recorded what had been offered to a person not what they had actually eating. During our visit we saw staff asking people at 12.15 what they

had eaten for breakfast. The guidance to staff from the Trust states that records should be made before the red trays are removed. The accuracy of the record could not be relied on to give a clear picture of a person's nutritional intake as they were not completed in accordance with the Trusts own guidance.

Occupational therapy staff told us that specialised equipment such as large grip handles was not available as there was a lack of money. Management disagreed and told us that these items can be purchased. We had observed during the visit that some people had needed specialist equipment in order to maintain their independence. Senior management reassured us that this was a quickly addressed action and that they would make sure that eating support equipment would be made available for all wards as needed.

**Our judgement**
People staying in Whiston Hospital are not consistently supported to have adequate nutrition and hydration.

# Action
we have asked the provider to take

## Improvement actions

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

| Regulated activity | Regulation | Outcome |
|---|---|---|
| Treatment of disease, disorder or injury,<br>Diagnostic and screening procedures | 17 | 1 |
| | **Why we have concerns:**<br>People staying in Whiston Hospital have their privacy, dignity and independence respected. Individual views and experiences are not always explored or recorded sufficiently for them to be taken into account in the way the service is provided and delivered. | |

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

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

The provider's report should be sent within 14 days of this report being received.

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

## Compliance actions

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

| Regulated activity | Regulation | Outcome |
|---|---|---|
| Treatment of disease, disorder or injury,<br>Diagnostic and screening procedures | 14 | 5 |
| | **How the regulation is not being met:**<br>People staying in Whiston Hospital are not consistently supported to have adequate nutrition and hydration | |

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

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

The provider's report should be sent to us within 14 days of this report being received.

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

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

# What is a review of compliance?

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

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

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

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

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

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

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

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

## Dignity and nutrition reviews of compliance

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

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

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

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

## Information for the reader

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