

Dignity and nutrition for older people

Review of compliance

Queen Victoria Hospitals NHS Foundation Trust
Queen Victoria Hospital

Region: South East

Location address: Queen Victoria Hospital
Holtye Road
East Grinstead
West Sussex
RH19 3EB

Type of service: Acute Services

Publication date: June 2011

Overview of the service: The Queen Victoria Hospital is a leading specialist centre for reconstructive surgery and rehabilitation, helping people who have been damaged or disfigured as a result of disease (including cancer), trauma, burns, major surgery or a congenital condition.

	<p>The hospital provides a minor injuries unit and community services for people living in and around East Grinstead and is situated on the outskirts of the town.</p> <p>Founded as a cottage hospital in 1863, Queen Victoria Hospital was built on its current site in the 1930s and developed as a specialist burns unit by Sir Archibald McIndoe during World War II, when it became world famous for pioneering treatment of RAF and allied aircrew who were badly burned or crushed and required reconstructive plastic surgery. Most famously, it was where the Guinea Pig Club was formed in 1941, as a club which then became a support network for the aircrew and their family members.</p>
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Summary of our findings for the essential standards of quality and safety

What we found overall

We found that The Queen Victoria Hospital was meeting both of the essential standards of quality and safety we reviewed.

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 is 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 focus on whether they are treated with dignity and respect and whether their nutritional needs are met.

How we carried out this review

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.

We reviewed all the information we hold about this provider and carried out a visit on 05 April 2011. We visited two wards, Jubilee and Margaret Duncombe. We observed how people were being cared for, talked with seven people who use services, talked with 10 members of staff, checked the provider's records, and looked at records of people who use services.

What people told us

People who use this service said that they felt supported by the staff to receive the care they need. They told us that every effort is made by the staff to help them maintain their mobility, independence and regain confidence to help them live independently when they are discharged. We spoke to many patients who said they felt included in their care, were able to express their preferences and contributed with

goal setting for discharge. They were able to make choices in their daily activities and what food they wished to eat.

During our visit we spoke with people on two wards who had been in the hospital between 3 days and 5 weeks and they told us they were very happy with the care provided. In general they were confident that the doctors and nurses made the right decisions about their care and treatment but some were not always sure that they fully understood all the details. They said that when they asked or needed things explained in more detail the ward staff took time to explain things more clearly and were good at making sure people understood about their illness, their treatments and care, even at busy times.

General observations made by inspectors throughout the day found that overall staff talked politely, respectfully and treated patients with dignity when giving treatment or care. When we looked at a selection of nursing records and care plans we could see that these documents clearly recorded what treatment was required and received, together with important references to the patients' ethnicity, religious needs and preferences.

During our visit we saw lunch being served both in the dining area and within the wards. Staff told us that they encouraged people to eat in the dining room whenever possible to help regain mobility and engage with other people. We saw that those people that needed some support and encouragement to eat their meal were treated calmly by staff in a dignified manner and given appropriate equipment to use. People told us they were always asked if they wanted a choice of drinks and that hand washing wipes were available for them to use prior to eating.

We asked people on each ward what they thought of the food, and they all reported that it was of good quality with plenty to choose from. On the day of our visit the food looked appetising and patients were keen to tell us that the food was always hot, well presented and there was an excellent roast dinner on Sundays. One person said "It's the best hospital food I've had" and another person told us that "food is excellent here and I am a very fussy eater so not easy to please".

What we found about the standards we reviewed and how well The Queen Victoria 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 The Queen Victoria Hospital was meeting this essential standard.

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

- Overall, we found that The Queen Victoria Hospital was meeting this essential standard.

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

The provider is compliant

with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

During our visit we spoke with people who said that they felt supported by the staff to receive the care they need. They told us that every effort is made by the staff to help them maintain their mobility, independence and regain confidence to help them live independently when they are discharged. We spoke to many patients who said they felt able to express their preferences including what they wished to be called and were able to make choices in their daily activities and what food they wished to eat.

Throughout the visit we observed staff talked politely, respectfully and treating patients with dignity. Patients told us that although they were confident that the doctors and nurses made the right decisions about their care and treatment, they were not always sure that they fully understood all the details. They said that when they asked or needed things explained in more detail the ward staff took time to explain things more clearly and were good at making sure people understood about their illness, their treatments and care. They said that staff were happy to do this even when they were busy.

During our visit, we saw staff checking frequently that patients were okay, listening to patients' needs and responding to any concerns. We saw that call bells were placed on beds in easy reach of patients and were told by patients that generally they were answered promptly.

Our observations showed that people were being involved in making decisions about their care which we were able to confirm when speaking to them. When we reviewed nursing and care records there was documentary evidence in place, to show that a range of professional multi disciplinary input was being recorded to ensure that patients were receiving care to reflect their individual needs.

Other evidence

Information we hold about Queen Victoria Hospital show that we have no reason to believe that there are risks that they are not meeting this standard.

We spoke to seven members of ward staff who told us that training in patient involvement, privacy and dignity was part of the mandatory annual training programme. The trust has a procedure on patient privacy and dignity and staff appeared knowledgeable about the procedure and explained how they had attended training in customer care that covered human rights and the importance of maintaining people's privacy and dignity. They gave examples of how this had informed their practice, including talking to patients privately, use of private rooms and involving patients in their day to day care. Staff commented that issues such as promoting patients' independence and privacy were also discussed as general practice at handovers, team meetings and ward meetings.

A senior member of staff told us how care planning had been reviewed to reflect and record more involvement from patients. Documents that we reviewed showed the involvement of multi disciplinary professionals including occupational therapists, dietitians, tissue viability nurses, psychology teams or the geriopsychiatrist where appropriate. We were able to see that people were involved in planning the care they received and where they were not capable of making their own informed decisions, evidence was in place to show that mental capacity assessments had taken place with the appropriate consent obtained from involving staff, relatives or next of kin.

Senior ward staff told us that regular audits of privacy and dignity were undertaken, and that training and education increased staff awareness of measures. The clinical lead on the ward oversees privacy, dignity and patient involvement, and any behaviour which was not respectful would be challenged. This would include the behaviour of doctors, for example if a high number of doctors visited a patient at one time. Staff told us that they liaised with community groups such as the Red Cross, and that there was a group for head and neck cancer at the hospital, and one for burns. All staff that we spoke with said they would directly challenge any issues which they felt compromised patients' dignity.

Staff talked about a culture of respecting patients, and during our visit we observed that staff talked to patients respectfully, patiently and in a quiet friendly way. They told us about procedures that are in place in order to maintain high awareness of privacy and dignity on the ward. These included toilet and bathroom facilities,

drawing curtains around patients' beds, role modelling and acting as patients' advocates. We were told that it was standard practice for doctors attending female patients undergoing reconstructive breast surgery, to always request a chaperone for examinations. We saw that curtains were closed around patients' beds when they were receiving treatment and care. Staff talked gently to patients, checking and asking permission before administering care. We observed that staff asked patients regularly if they were okay and if they needed anything. When asked they met patient needs quickly. We observed staff re-positioning patients with care when requested or prior to eating or drinking.

During our visit we found that people's care records detailed fully their complex needs, contained appropriate assessments and identified individual preferences and preferred routines. Staff were able to describe that they provide care according to the needs and wishes of the person they are treating. The tissue viability nurse explained to us that specialist advice on wound care and nutrition is essential to aiding the healing process and to ensure patients are at their optimal condition prior to surgery a variety of blood tests are undertaken to establish if anything lacking which may affect their healing process.

We sampled the care plans for four people during our visit, and the guidance for staff on providing the care included a record of how the person usually wished their care to be provided. These records were found to contain full assessments from admission and review, including ongoing nutritional needs with those at risk clearly identified. Staff we spoke to appeared knowledgeable about which patients required support to eat and drink or those with particular nutritional needs. Dietitians and therapists regularly visit the wards and patient's records showed their involvement in patient's assessments and ongoing review of their care. This was particularly prevalent with patients who were at greatest risk.

We asked staff how they ensured that patients could make informed choices. Staff told us about the importance of ongoing communication, and that they would often follow up doctors' explanation of treatment to answer questions in a way which the patients could understand. We spoke to the hospital dietitian, who said that nutrition was discussed with patients on a daily basis, and was also discussed in multi-disciplinary team meetings. She told us that treatment options, risks and benefits were explained to patients at the bedside, and that she would often go back and explain again as sometimes it was a lot to take in. The dietitian told us about the importance of patient choice relating to feeding options, and that if a patient did not want a feeding tube to be inserted then they would provide alternative nutritional support. A senior nurse on the surgical ward told us that sometimes decisions have to be made quickly, for example head and neck patients may be diagnosed and treated within a month; in these cases the psychological therapies team would be involved to provide support in making decisions, and the doctor may come several times to explain the treatment options.

Staff showed us the information leaflets about the hospital and facilities provided at pre-assessment and admission which include information on ward routine. The publications also identify any clinical staff who will be seeing the patient during their stay. Specialist information leaflets on treatment are given in clinics and to

inpatients when relevant. The dietitian told us that she explains what will happen and how it will be followed up, including the importance of nutrition to recovery. We spoke to patients on the surgical ward who had clearly got the message about the importance of nutrition for wound healing and recovery. One nurse told us that they could always call on specialists to provide additional information when needed, for example the dietitian or head and neck clinical nurse specialist.

Staff told us the importance for gaining patient's views on their care by constant communication with individuals. They told us that the best information was gained from involving people and speaking directly with them, asking if they needed anything or if they were comfortable or in any pain. With some patients who found it difficult to communicate they said it was important to observe them and watch for body language for information, involving family members as and when possible. They said that the admissions process would identify a patient's individual social and cultural needs, and that this would be documented at this stage. Staff would then ensure they met the identified need in a range of ways, including communication with colleagues, handover meetings, contacting the chaplain or external organisation. If a patient had specific dietary needs, they would discuss this with the catering team and dietitian and come up with an individual menu plan.

A staff member on the community and rehabilitation ward told us that their rehabilitation programme was specifically designed to promote patient independence. The community and rehabilitation ward has a day room and dining room, and everyone is encouraged to eat their meals in the dining room. We observed a physiotherapist and a member of nursing staff encouraging and assisting a patient to get out of bed. This was done with the curtain closed, and the staff members were very respectful of the patient's wishes and anxieties, and friendly and reassuring in their communication. A member of staff on the surgical ward told us that they would assess patient's support needs and would support them to be independent as much as possible, for example encouraging them to change their own dressings if possible. The psychology team might be involved.

Staff highlighted how the inpatient questionnaire is undertaken with individuals prior to discharge. Issues identified may be addressed there and then, or escalated, and positive feedback is shared. Where patients have particular communication needs, their carer or advocate may be involved. They also have access to interpreters, and will sometimes work with the speech and language therapists (SALT) who have special equipment which may be helpful.

We asked staff if they could give us examples of any changes to practice in response to feedback. The dietitian told us that they have changed the menu to remove less popular choices, and have also changed the mousse as people didn't like it. On the surgical ward, they used to make breakfast on the ward, but now all food comes from the kitchen, which offers a better service and includes a cooked breakfast. A staff member on the community and rehabilitation ward said that they had introduced a red tray system to identify patients who need extra support to eat their meal. Staff told us that many people recovering from surgery had told them that they fancied something light like soup or toast and they were now able to provide this when necessary.

Staff told us that complaints information was available on request, and that they would explain to patients how to make a complaint, either informally or formally. One member of staff said she would ask a member of staff from the Patient Advice and Liaison Service (PALS) to come over and talk to a patient if necessary. Concerns may be dealt with at the time, or could be escalated to a matron. In entrance areas to both wards posters about who to make a complaint to and how to contact the PALS team were displayed throughout the hospital. Information on the service was also detailed in the booklets designed for patients such as "The bedside guide for patients" and "Information for In-patients. When we asked people if they knew how to make a complaint, some said that although they were not fully aware of the formal system in place they knew who to speak to on the ward if they were unhappy about anything. Generally we were told that people had nothing to complain about and were very happy with all aspects of their care.

Information and documentation previously supplied by the trust together with discussion with ward staff provided evidence that the trust undertakes surveys of its patient population and acts on the feedback. Complaints are monitored at board level and analysed for any trends or serious concerns so that they can be used to improve patient care. The Board of Governors operate a monthly walk around throughout the hospital and there is an active patient information group that constantly addresses issues and ensures that patient information leaflets reflect current practice. The Public Engagement Committee which is a representative user group made up of people who are using the service are actively involved in reporting and addressing shortfalls identified.

Our judgement

We found that the Queen Victoria Hospital takes steps to ensure that the privacy, dignity and independence of people are promoted. Information is provided about the service to help people make choices. Care is based on the individual needs of each person and there are opportunities to help people make choices in their daily lives.

Following our review of all the evidence we have received and from our visit to the hospital we believe the Queen Victoria Hospital to be compliant in respecting and involving people who use services.

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

The provider is compliant

Our findings

What people who use the service experienced and told us

During our visit we saw lunch being served both the dining area and within the wards. Staff told us that they encouraged people to eat in the dining room whenever possible to help regain mobility and sociability. We saw that those people that needed some support and encouragement to eat their meal were treated calmly by staff in a dignified manner. People were asked if they wanted drinks and were offered a choice. The equipment people needed was provided and staff wore aprons and gloves when serving food. Hand wipes were available for patients to use although we did not observe people being actively encouraged to use them before eating.

We asked people on each ward what they thought of the food, and they all reported that it was good. On the day of our visit the food being served was hot, presented well on trays and looked appetising. People told us there was always a good choice, including snacks available all day and that the roast dinner on Sundays was excellent. They said they usually got what they asked for or offered a suitable alternative if they wished. Staff quickly found a meal for a patient who had not ordered the previous day, and she told us that she was very happy with the choice. One person said “It’s the best hospital food I’ve had” and another person told us that “food is excellent and I am a very fussy eater so not easy to please”.

Other evidence

Information we hold about Queen Victoria Hospital show that we have no reason to believe that there are risks that they are not meeting this standard. The hospital was able to demonstrate that they have systems in place to ensure that patient care plans record the appropriate information in a clear and comprehensive format. Regular audits are undertaken and records kept of any actions taken to address shortfalls.

In the Patient Environment Action Teams (PEAT) inspections Queen Victoria Hospital food scored excellent for choice, availability and presentation. PEAT is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

Specialist staff such as dietitians, speech and language therapists (SALT) and physiotherapy teams are available for advice, planning and support for patients and staff. The dietitian provides nutritional support for a variety of conditions such as diabetes. Patients with specialist feeding regimes such as PEG or NG feeding are discussed at the multidisciplinary team meeting which includes allied healthcare professionals. The SALT team recommendations are adhered to and staff felt it provided good support for the ward staff and patients.

We spoke to five senior members of ward staff who told us that the Malnutrition Universal Screening Tool (MUST) is used on admission of all patients to identify the patient's level of risk of malnutrition. All inpatients are then screened weekly for the duration of their admission. Action taken depends on the MUST score, and could include monitoring of weight, completing food and fluid intake charts, or referral to the hospital dietitian. All staff we spoke to told us that they had very good access to the specialist staff they need, and that specialist staff are included in the multi-disciplinary team. One member of staff said "If you want something done, it is just done straight away".

Staff told us that they had received training on nutrition, including a study day on dysphagia (difficulty in swallowing), training on tube feeding, and training on working with maxillofacial patients who have had surgery on the head, neck, face and jaws. Staff told us that the dietitian does a session at the trust induction day, and that there is a refresher course on nutrition once a year. The dietitian explained how she gives a lot of training across the trust, including focused study days and seminars, and provides training externally, for example to nursing home staff, and to students. A senior member of staff told us that a housekeeper who had received dysphagia training correctly identified that a patient may have difficulty swallowing and should have been highlighted as nil by mouth, and asked a nurse before giving her a drink so preventing a potential incident.

There are systems in place to ensure patients get enough support to eat and drink, including a red tray system for identifying patients who need support at mealtimes. There are lots of staff available on the wards at mealtimes, especially on the community and rehabilitation ward, and staff are rotational so have all had training and experience of nutritional issues. There is support on the ward from healthcare assistants and housekeepers, who have all had nutritional training, to make sure

patients choose appropriate meal choices and include snacks in their diet. The dietitian felt that the trust as a whole is very pro-nutrition, and that she is a part of the multi-disciplinary team and is listened to. When she makes a request, for example for tube feeding, this is actioned very quickly. Nutrition is discussed for every patient at their multi-disciplinary team meeting, and trust-wide nutrition issues are discussed at the weekly multi-disciplinary team meeting.

Other staff told us that the dietetic assistant plays a key role in assessing patients and identifying those who are at risk of malnutrition. Staff said there is always a healthcare assistant or housekeeper available to sit with patients and provide support if needed. The clinical lead takes an overview of nutrition on the ward as part of the role, and there is also a team of ward-based nutrition link nurses. There is a multi-disciplinary Nutrition Steering Group which meets three times a year, and oversees nutrition for the trust. Audits which are undertaken, such as MUST audits, protected mealtimes audits, and audits relating to tube feeding, are reviewed by this group.

During our visit, we observed lunchtime on the female surgical ward and the community and rehabilitation ward. Food is cooked in the kitchen on-site and is plated up to be transferred to the wards according to the orders received. The food was served from a heated food trolley by staff including nurses, healthcare assistants and the housekeeper. It was noted that hand wipes were either placed on the meal trays by staff or available at the bedside for patients to use for hand cleansing, although we did not observe patients being encouraged to use them. We observed a member of staff assisting someone with eating in a friendly, helpful and respectful way. This person did not receive their meal on a red tray; there was no one with a red tray on the ward on the day of our visit. We asked the clinical lead for the ward about this; she said that the red trays were not really required as staff knew the patients so well that they would always provide support if needed. A range of appropriate utensils were available for people to use including easy to grip cutlery and drinking beakers.

The wards we visited were quiet and peaceful during the lunch period and patients were not interrupted during this time with both wards operating protective mealtimes for a 30 minute time period to enable patients to eat their food in a calm environment. There appeared to be plenty of staff available to assist patients. We observed a bay of three patients being served and eating their lunch; they were not interrupted while eating, and a nurse who came round to do the medication round confirmed with the patient that she had finished eating before she started talking about her medication. However, one patient told us that she was often given medication during her mealtime.

The hospital has a robust process in place to determine patients' medical, dietary and hydration requirements. All patients are assessed for nutritional support within the trust as a matter of course and the organisation has a protected mealtimes policy in place. Within the hospital link nurses work in ward areas and meet quarterly as part of the Link Nurses Group and Nutrition Steering Group. We were shown the results of the most recent audit undertaken in January 2011 which is designed to be an observational audit for patients throughout the hospital. Patients

are interviewed to ascertain their understanding of the menus and asked for their comments on choice of food and food presentation. They are also canvassed to find out if the food they receive is hot when served and what they actually ordered. Recommendations from these audits are shared directly with kitchen staff, Nutrition Steering Group and link nurse meetings.

The members of staff we spoke to also think the food served is of good quality. They said there was a good choice and that special diets are provided for by the kitchen, sometimes an individual menu will be developed with the dietitian and the catering team. One member of staff on the community and rehabilitation ward told us that patients were sometimes put off eating by portions which were too large. She said that staff would check the meals before giving them to patients, and may take some food off the plate to make the food more appealing. She said it was also possible to request an individual smaller sized portion from the kitchen; the dietitian said she had done training on portion size with the chefs. If a patient ate a smaller meal, this would be recorded on their food chart so that additional supplements could be provided if necessary. One member of staff said they did not always get pureed food or a soft choice diet from the kitchen as requested, and sometimes they did send meals back.

The dietitian explained that the nutritional value of all meals is planned and analysed using a computer package. This helps them to cater for special diets, such as high protein diets which are commonly needed for patients with burns. The range of choices includes pureed food, a soft choice and a specific texture diet, which are very important for stroke patients and those who have had head and neck surgery. The dietitian said that food and fluid charts are well-used, and are very easy to complete as the menu is listed and staff only need to complete the proportion of food eaten, e.g. half, one quarter, three quarters. This information is used to analyse what patients have had, and to calculate how many nutritional supplements they will need, according to their individual calorie and protein requirements. Full fat milk is supplied and found to be available throughout the wards for use in preparing patient drinks.

Information on meals is provided for patients in the bedside guide with the menu choice circulated in the ward on a daily basis. Staff on the wards said that healthcare assistants and housekeepers were responsible for taking patients' food orders. These are done the day before. Patients are informed verbally of the choices, and additional support is available if required. The staff involved told us that they have received nutritional training, and are aware of how to promote good nutrition. They said that there was usually enough time for this personal service and that if anyone needed help they would get it. The dietitian told us that there were rehabilitation assistants on the ward who could provide extra support in making appropriate choices.

Three meals a day are served with special emphasis being placed on snacks and refreshments which we observed being served throughout the day. Patients told us that if they wanted something specific staff would always arrange it for them and in agreement with the dietitian.

Staff told us that the food delivery service from the kitchen was good, that the food came at the right time and that they ensured it was the right temperature before serving from the trolleys. One member of staff said they sometimes received the wrong orders, and would go back to the kitchen for the right order if this happened. Staff noted that if patients decide they do not want the food when it arrives, an alternative is offered and we observed this in practice when a patient was offered a lighter option for lunch. We saw that the member of staff spoke quietly with the patient and arranged the alternative with a minimum of fuss. The patient told us that “staff are wonderful and cannot do enough to help you”.

Our judgement

Following our review of all the evidence we have received and from our visit to the hospital we believe the Queen Victoria Hospital to be compliant with respect to meeting the nutritional needs of patients who use services.

What is a review of compliance?

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

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

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

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

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

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

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

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

Dignity and nutrition reviews of compliance

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

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

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

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

Information for the reader

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