Dignity and nutrition for older people

Review of compliance

North Middlesex University Hospitals NHS Trust
North Middlesex University Hospital

Region:	London
Location address:	Sterling Way, London N18 1QX
Type of service:	Acute Services
Publication date:	June 2011
Overview of the service:	North Middlesex University Hospital serves a population of more than 500, 000 people living in the London Boroughs of Enfield and Haringey and surrounding areas including Barnet and Waltham Forest. The hospital has approximately 360 beds and provides a range of specialist care. These specialist services include Stroke, HIV/AIDS, Cardiology (including heart failure care), Haematology, Diabetes, Sleep Studies, Fertility and Orthopaedics. In

	addition the Helen Rollason Cancer Support Centre provides supportive services to people with cancer. This is one of only two such centres in London. The accident and emergency service sees over 150,000 people a year.

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

What we found overall

We found that North Middlesex University 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 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

We reviewed all the information we held about this provider, carried out a visit, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services. We visited two wards in the hospital, Michael Bates Ward, which specialises in care of the elderly and S1, which is a surgical ward. We spoke to seven patients or their relatives and seven members of staff on the two wards.

The inspection teams were led by CQC inspectors joined by a practising, experienced nurse. The inspection team also included 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.

What people told us

All the patients and relatives we spoke to were happy with the care and treatment they received from staff. They were treated with dignity and respect and one patient said staff ‘bent over backwards to help’. Staff were described as ‘kind’ and ‘careful’ and were said to respond quickly when patients needed assistance. Patients told us they had a wide selection of meals to choose from and there was plenty of it. There were mixed views on how appetising the food was and one person said ‘no one really enjoys hospital food’. The food was described as ‘always hot’ and mealtimes were said to be unhurried.

What we found about the standards we reviewed and how well North Middlesex University 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 North Middlesex University Hospital was meeting this essential standard.

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

- Overall, we found that North Middlesex University 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

We spoke to patients and relatives on both wards and asked them how they were involved in their care and treatment and whether they were treated with respect by staff. Everyone told us they were happy with the care they received. Staff were described as ‘kind’, ‘careful’ and ‘excellent’ by different people. One patient told us that staff ‘bend over backwards to help me’.

Patients told us they were treated with dignity and respect and that their needs for privacy were always taken into consideration. They told us that staff always pulled the curtains around the bed before giving personal care. Even when patients could not easily express their needs they were treated with respect. For example, one relative whose mother suffered from dementia told us ‘she is always dressed and looking smart…that is the way my mother likes it’. Other patients told us they were listened to by staff and staff always asked for consent before carrying out procedures.

Patients told us that staff generally responded quickly to their needs and call bells were answered promptly, even at night. One relative told us that her mother was not able to use the call bell but staff were aware of this and checked her regularly.

Patients told us they were given useful and relevant information in relation to their stay in hospital and care and treatment options. Several patients told us their families had been involved. Relatives on both wards told us they were kept informed of their family member's progress by staff.

Other evidence

We observed staff interacting with patients in a kind and caring manner. Staff were respectful and always pulled curtains around the patient's bed before carrying out a procedure or giving care. We saw a nurse communicate with a patient, who was hard of hearing, using pen and paper rather than shouting in order to be heard. This demonstrated respect for the patient's privacy. Care was delivered in an unhurried manner and patients were not rushed. We heard staff explain what they were doing and involve patients in their care.

Michael Bates was a female only ward and on S1 there were female only bays and patients had no difficulty accessing single sex toilets and bathrooms.

Where staff were concerned about the mental capacity of patients to make decisions formal assessments of capacity were made. Staff gave a number of examples of situations where patients were found to have capacity and their wishes were supported even where staff disagreed. We saw a completed capacity assessment form in one patient's records.

Where patients had difficulty understanding or communicating, staff used a range of sources to gather information about them so that they could provide care in a way the patient preferred. This included obtaining information from care homes where appropriate. We saw patient food preferences, supplied by relatives, displayed on the wall behind their beds. Patients' cultural needs and individual preferences were also taken into account.

We reviewed a number of patient records on both wards and found risk assessments completed on admission. Where needs were identified some generic care plans were in place. However, it was not always clear what action had been taken in response to an identified risk and how concerns were escalated.

Call bells were generally left within the reach of patients and staff responded promptly when these were used. Additional support was given to patients who needed it although attempts were made to allow and encourage them to be as independent as possible. This showed that staff were sensitive to patient's needs.

Patients and relatives were given leaflets in relation to their care and both wards had a large notice board displaying a range of useful patient information. On Michael Bates there was a notice offering relatives and carers meetings with senior

nursing staff at evenings or weekends if they had difficulty visiting during 'office hours'. There was also information available on the Patient Advice and Liaison Service.

Staff on both wards had gathered feedback from patients via satisfaction questionnaires and a Patient Electronic Tracker (PET). This had resulted in changes being made to practice on the wards. Results from the PET surveys were displayed. Feedback from PET monitoring across the hospital in 2011 showed that 79% of patients felt involved in decisions about their care and 89% had been treated with dignity and respect.

Trust policies set expectations for staff in relation to their behaviour when interacting with and caring for patients. Members of the Trust Board and senior management made regular visits to the wards to observe care delivery and spoke to patients about their experiences. Trust audits of the protection of elderly patient privacy and dignity found good use of curtains and screens on all wards monitored in February 2011. The majority of staff had received or were about to receive customer care training. Evaluation of the training stated it had been effective in improving staff attitudes towards patients.

Our judgement

Patients were enabled to participate in decisions about their care and treatment and decisions made by patients were respected. Appropriate information was provided to patients and their relatives or carers. Overall, patients were treated with consideration and respect, independence was encouraged and their privacy was protected.

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

with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

We asked patients what they thought of the food and drinks provided to them. Everyone told us there was a wide range of meals to choose from on the menu. Patients were assisted to make meal choices by the ward hostess. Whilst this appeared to work well for most patients, one patient told us that she would rather be given a form to fill in so that she would have more time to think about her choices. Several patients said they had been asked what they preferred to eat. Some said they were offered hand wipes to clean their hands before meals and one patient showed us a bottle of hand cleaning gel kept at her bed side.

Patients told us there was plenty of food available although there were mixed views on how appetising the meals were. One patient said ‘no one really enjoys hospital food…but they now do sandwiches and a side salad, I love that’. The food was described as ‘always hot’ by several patients and meal times were said to be quiet and unhurried.

Patients told us that staff checked how much they had eaten. They were provided with a range of snacks and some described asking for staff a cup of tea between snack times and these being provided. However, one patient reported that she sometimes missed her cup of tea after lunch because she was asleep.

Other evidence
The wards operated protected meal times to ensure that patients received the nutritional intake they needed and interruptions from clinical staff were actively discouraged. Malnutrition Universal Screening Tools (MUST) were completed for all patients on admission and those deemed to be 'at risk' of malnutrition were given a 'red tray'. Trust audits of keeping elderly patients nourished and hydrated in February 2011 found that protected meal times were being implemented, 'red trays' were being used and patients were assisted to eat in all clinical areas.

The dietitian on Michael Bates told us that each meal is acceptable in terms of nutritional value. However, there was generally not enough fibre in the meals and she was running a trial on another elderly care ward where patients were given a glass of orange juice with their meal.

We observed the lunchtime meal time on both wards. The food appeared to be appetising. Patients were assisted to clean their hands with hand wipes or gel before and after eating and napkins were provided. We saw a number of patients with 'red trays' who were helped to eat by staff. Where patients were being fed by nurses this was done sensitively. We also saw staff open packets for patients where they could not do this for themselves.

Patients were helped to position themselves comfortably to eat and meals and drinks were left within easy reach. The environment was quiet, calm and unhurried and there were no interruptions. There was at least one nurse in each bay throughout the meal. Three patients ate their meal together at the dining table on Michael Bates where they received assistance and encouragement from staff.

Patient records showed that patients were weighed at least weekly and where concerns were identified food and fluid monitoring put in place. We saw that MUST forms were completed for all patients and that generally monitoring of food and fluid charts were completed, although there were a few gaps. All patients had on-going nutritional screening until discharge.

Patients who needed to be were referred to the dietitian and usually seen within 24 hours. We saw in patients' records that the dietitian had prescribed food supplements to patients and checked whether they had been given. This showed that regular nutritional screening and monitoring was taking place.

Staff told us that they asked patients and their relatives about their preferences when it came to food and drink. They also used a picture menu to help older patients make their choices. The dietitian told us that she would sometimes contact a care home to find out what a patient liked to eat. A list of food preferences was seen on the wall behind the beds of several patients on Michael Bates.

Menus showed that patients had more than twenty choices of meal per day. Special diets were catered for including Halal, Kosher, gluten free and soft diets. Special diets were ordered for patients who needed them and these were generally available within 24 hours. Cultural and religious preferences were taken into

account. Snacks were available on a regular basis.

The Trust monitored patient satisfaction with the food provided and feedback obtained in 2011 showed 81% of patients thought they had been an adequate choice of food. Managers audited their clinical areas at least once a week checking the MUST documentation and carrying out spot checks with patients. The Trust reported that, as a result, improvements had been made in weight monitoring, and the use of the MUST. The assistance given to patients' to eat had also improved following a re-launch of the 'red tray' initiative.

Staff were trained in nutritional requirements, completing the MUST, assisting patients to eat and drink and feeding dependent patients.

Our judgement

The Trust had processes in place to identify and monitor people who were at risk of poor nutrition and hydration and these were generally being implemented consistently. Protected meal times were in place and patients were given assistance to eat and drink where appropriate. Nutritional assessments of patients were completed and food and fluid intake usually monitored where risks were identified. As a result patients were being protected from the risks inadequate nutrition and dehydration.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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