Dignity and nutrition for older people

Review of compliance

North Cumbria University Hospitals NHS Trusts Cumberland Infirmary	
Region:	North West
Location address:	Cumberland Infirmary Newtown Road Carlisle CA2 7HY
Type of service:	Acute Services
Publication date:	June 2011
Overview of the service:	North Cumbria University Hospitals NHS Trust, (the trust) is an acute trust providing hospital services and treatments to a population of 340,000 people. The trust is located in one of the most geographically remote areas and serves the third most sparsely distributed population in England. The trust operates from two acute hospital sites providing secondary

	care to the residents of Carlisle, Eden, Allerdale and Copeland, together with parts of Northumberland and Dumfries and Galloway. During 2009/10 the trust saw 418,523 patients between it's two hospital sites; Cumberland Infirmary in Carlisle and West Cumberland Hospital in Whitehaven. Cumberland Infirmary is a purpose build hospital with 395 beds serving the population of north Cumbria. The hospital is situated in the city of Carlisle and has good public transport and road access.

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

What we found overall

We found that Cumberland Infirmary was meeting both of the essential standards of quality and safety we reviewed but, to maintain this, we suggested that some improvements were made.

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. At this review we visited Elm A and Maple C/D wards within Cumberland Infirmary and spoke to eight patients about the care they received whilst in hospital.

We reviewed all the information we hold about this provider, carried out a visit on 17 March 2011, 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.

What people told us:

Patients who were interviewed on the day expressed that they were satisfied with care and treatment given to them during their stay at the Cumberland Infirmary.

They told us that staff respected their views and that they were always helpful, polite and explain everything to them. Patients also told us that they felt that their care needs were being met and that staff responded quickly to their needs.

Patients told us that they were generally satisfied with the care given in meeting their nutritional needs. They also told us that the food choices, availability, presentation and special diets were of a good quality. All patients spoken to felt the choice of menu was good, and most of the meals they received were appetising and hot.

The hospital's own patient satisfaction survey shows within their dignity and privacy data all wards included in the survey between January and March 2011 scored a 100% satisfaction score with a large proportion of inpatients expressing satisfaction with care, treatment, privacy, dignity, information and treatment with respect.

There were two complaints received by the trust in relation to outcome 1 between April 2010 – March 2011 but there were no complaints received regarding outcome 5 for the same period. Two positive comments were reported through NHS Choices between June and December 2010 about the care received.

The hospital provided several reports which demonstrate they seek and monitor patient satisfaction on a regular basis, this work is across all inpatient areas. The patient satisfaction surveys demonstrate a high level of satisfaction with care, treatment, privacy, dignity, information and treatment with respect in the months of January and March 2011. The results also support high levels of satisfaction with menus, meal choice and dietary requirements.

What we found about the standards we reviewed and how well Cumberland Infirmary 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 Cumberland Infirmary was meeting this essential standard

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

- Overall, we found that Cumberland Infirmary was meeting this essential standard.

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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

Patients who were interviewed on the day expressed that they were satisfied with care and treatment given to them during their stay at Cumberland Infirmary.

They told us that staff respected their views and that they were always helpful, polite and explained everything to them. Patients also told us that they felt that their care needs were being met and that staff responded very quickly to their needs.

On the day of the visit patients told us:

"I have been in hospital for 3 weeks. I have found the staff excellent; they call me by the name I like. I feel like I am listened to and this couldn't be better. Staff explain things to me before they start and always ask if this is ok. I have never felt embarrassed or uncomfortable during my stay. I feel I could talk to someone about my concerns if I have any"

"I am very well cared for. I was asked about the name I wish to be called by and they do this. I feel listened to. I have never felt embarrassed"

"I have been here a week. Staff are very good, they told me why I needed a scan but they do not always draw the curtains when they are assisting me."

The hospital's own patient satisfaction survey supports this. Within their dignity and privacy data all wards, included in the survey between January and March 2011, scored a 100% satisfaction score with a large proportion of inpatients expressing satisfaction with care, treatment, privacy, dignity, information and treatment with respect. The data also shows that there has been an improvement in results compared with 2010,

The trust confirmed that analysis of complaints demonstrated there was only one complaint made to the trust regarding care at Cumberland Infirmary which was from a patient about being disturbed by noise during the night.

Two positive comments were reported through NHS Choices between June and December 2010 about the care received at the trust's locations. The comments praised the staff involved and the care received at the Cumberland Infirmary. One negative comment indicated the patient did not understand the information received from staff.

Other evidence

Review of information we hold supports overall that patients think the trust treats them with respect and dignity however the one area reported in the patient survey 2009 shows that the majority of data items under Outcome 1 specifically relating to dignity were at least '*similar to expected'*. The exception to this was the proportion of respondents to the adult inpatient survey (2009) who stated that they did not have enough privacy when discussing their condition, treatment, being examined or receiving care which were both deemed '*worse than expected'*.

Patient Environment Action Teams (PEAT) data (2010) indicates the environment at the Cumberland Infirmary is '*much better than expected'* for four indicators relating to the hospital environment being conducive to patient privacy.

We were told by staff that they receive mandatory training which covers the basics of dignity and privacy. This is developed at induction and then maintained throughout the general day to day work on wards. The trust's website for patient information tells us that they are committed to protecting and respecting privacy, to safeguarding comfort, privacy and religious and cultural needs at all times. Although most of the wards have both male and female patients, the trust will ensure that patients are cared for within a designated male or female area. Observation on the day confirmed to us that single sex bays were maintained, However due to the design of the wards there was a problem with 'line of sight' between bays which could impact on privacy and dignity, which the trust is aware of and continuously reviews ways of improving this.

We were informed that there are designated staff on the ward who are 'champions' for privacy and dignity. Essences of care audits are undertaken and the results are reviewed to support learning and improvement purposes. We were shown an example of a change which was taken as a result of a concern being raised by a patient about protecting privacy this was in relation to the opening of the en-suite doors in each bay. This has resulted in a curtain being added across the front of the door. ('Essence of Care' was first introduced in 2001 to support and address the fundamentals of care. It is a tool designed to help healthcare professionals take a

patient-focused and structured approach to the sharing and comparing of practice. The aim to support localised quality improvement is at the heart of the 12 revised benchmarks)

Observation on the day confirmed to us that patients were treated respectfully. We saw care sign placed in doorway of bays when personal care was being carried out which stated “Please respect people’s dignity as care is being undertaken”. Staff were observed to be respectful, using first term names, dealing with patients in calm pleasant manner and engaging patients in conversation. Staff came across as genuine, caring and cheerful. Staff were good at explaining to people what care or treatment they were about to give. However we noted that the ward environment contributed to a patient with dementia confusion, for instance they could not recognise their bay because all bays looked the same. During observation it was noted that two men walked into the women’s bay and had to be guided back to their own. Furthermore we observed two instances of staff asking for support or discussing patient care that did not respect the privacy of the individual patients.

We saw that patients have their name above the bed and this usually records what they like to be called. However most bays contain 5 beds which restrict the space and therefore the dignity and privacy of some patients. We were told that the curtains can sometimes not fit correctly leaving gaps or can be difficult to close.

We found evidence of information provided to a family recorded in one care plan with care, treatment, privacy, dignity, information and treatment with respect. Also documented were records of attempts made to discuss this with the patient but limited understanding caused a problem. However we saw in one care plan there were no choices or preference about care, religion or cultural preferences recorded but clinical care plans were well documented

Information provided by the trust in there own assessment told us that patients / carers receive information in a variety of ways regarding their care and treatment. These include information leaflets and the opportunity to discuss issues face to face so that they can make an informed choice before they consent to the procedure in line with the consent policy. Patients’ individual care, treatment and support is reviewed via their care plans and the opportunity for discussion during consultation with clinicians. The trust also stated that staff are trained on equality and diversity as part of mandatory training which also incorporates issues of human rights. There are several multi-disciplinary forums which enable clinical staff and patients to gain a shared understanding of service needs supported, however the trust acknowledges that an area they can improve is to ensure the Deprivation of Liberties training is cascaded further through the organisation, as it is applicable to more than just front line staff.

The information from the trust confirmed that with the introduction of monthly satisfaction surveys, they were proactively addressing any issues as and when they arise in order to offer the best care possible and ensure any issues or concerns are addressed promptly. The sister/charge nurse is responsible for this within their own area and this has created an ownership and greatly increased the pride staff take in their work.

The trust has developed a productive ward audit and results from this audit have influenced care delivery. The productive ward audit focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency. We were told that patient's needs are always documented in care plans, and this also records likes and dislikes. When we reviewed care plans we found them to document patient needs, cultural requirements and a social history regarding likes and dislikes. Staff confirmed to us that relatives were involved in care planning but within the care plans reviewed there was no recorded evidence of this. Staff told us that they use the time when performing personal care to discuss with patients their needs. Patients are asked to give consent to treatments and care which is supported by professional consent. If the patient does not have capacity this is done on a 'best interest' basis.

On observation we saw that call bells were in reach of patients. Staff were paying attention to people's appearance, straightening clothes and brushing hair. We observed one healthcare assistant re-covered a lady whose sheet had come off exposing her legs. Observation of patient records and discussions with staff confirmed that patients had individual assessments and plans of care and treatment. Their needs were assessed taking into account their choices and preferences.

Following the Health Service Ombudsman report on 10 investigations into NHS care of older people, the trust has developed an action plan which recommended the further development of the current patient experience feedback audits and will include: real time feedback from patients to include relatives and carers feedback, monthly reporting to the trust board through governance quality indicators on patient experience audits (to commence in April 2011), increased board to ward visits to be targeted on care given to older people and increased spot check visits led by senior nursing team for outcome 1.

We saw evidence of complaints leaflets but we were informed that staff will try to address issues as they arise. Staff accept verbal feedback but there are also satisfaction slips available for completion. There is also a system of real time satisfaction surveys being conducted by using volunteers with IPads, There was a housekeeper in post on one of the wards we visited. She explained that part of her role was to assist patients with feedback on care.

Within the information provided to us by the trust it was confirmed that privacy, dignity and respect issues are monitored in several ways; via monthly in-patient surveys, monthly essence of care audits and quarterly clinical indicator audits. Information was available via the trust's website and also patient leaflets, which are available in-patient waiting areas and wards, on how to make a complaint and about the Patient Advice and Liaison Services (PALs). The trust confirmed that it also ensures that feedback from key stakeholders such as Local Involvement Networks (LINks) is used in the monitoring and reviewing of the care they give to patients.

On the trust's website there is a section for patients to have their say. It states that the trust's aim is to ensure patients get the right treatment, at the right time and to the highest standard. They confirm that they believe the views and experience of patients is the real test of performance, and actively encourage patients to submit

their views via a link from the web page. There is also information regarding how to complain. The trust states that patient views are important and by making comments or raising concerns patients help the trust to understand how they see services and identify where improvements can be made. The trust also states that they are glad to hear about anything they are doing well

Our judgement
Many of the patients we interviewed were positive about their care and experience at Cumberland Infirmary. The trust can demonstrate that people who use services understand their care, treatment and choices available to them. People's privacy and dignity is recognised and staff seek people's views to influence the care, treatment and support offered. Any shortfalls identified on the visit were isolated.

Overall, we found that Cumberland Infirmary was meeting this essential standard.

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

Patients told us that they were generally satisfied with the care given in meeting their nutritional needs. They also told us that the food choices, availability, presentation and special diets were of a good quality. All patients spoken to felt the choice of menu was good, and most of the meals they received were appetising and hot.

"that staff always check to ensure I have had enough to eat and drink".

"the drinks from the machine, made in plastic cups, leaves an unpleasant taste in my mouth, and generally I don't like them".

"My lunch was kept warm for me when I had to leave the ward for an investigation procedure"

"I've been here a few weeks and as far as I have seen no one goes without food or drink. I've been very impressed with the time staff spend helping people, and people really perk up at mealtimes with the help of staff".

Questions relating to nutrition from the NHS inpatient questionnaire (2009) responses were '*about the same'* compared to other similar trusts in relation to the quality and choice of food and being given assistance with eating.

From the trusts own patient satisfaction survey results we can see that for January 2011 the scores were high for Cumberland Infirmary regarding menus, meal choice, dietary requirements, patient experience at mealtimes and assistance offered. Negative comments were recorded in relation to the taste and presentation of some meals.

Other evidence

Information we hold about the trust told us that the Cumberland Infirmary was '*much better than expected*' in relation to the menu choice, availability, and quality of food. Inpatient survey data indicated that the trust was '*tending towards better than expected'* with regard to providing help with feeding. PEAT data also showed the trust as '*similar to expected'* for nutritional screening and operating a protected mealtime policy.

A board report in March 2011 records that there was sufficient evidence against the requirement, however it was agreed that spot check assessments were to be carried out during March to review how this was being delivered in practice.

The trust also told us that they have a clear policy on nutrition management which is embedded across the organisation. To ensure that expert knowledge is available the trust also has in place nutritional link nurses on the wards areas as well as access to specialist nutritional advice from the dietitian. They further confirmed that some patient panel members have a huge interest in this area of nutrition and participate in the audits at the hospital. They told us that catering staff provide meals and nutrition that addresses the wide variety of religious and cultural needs of the people who use their services.

On our visit we found that wards have protected meal times and generally visitors were discouraged. However we were told that if a family member wished to come and assist their relative with eating this was readily accepted on the wards. There were good examples of staff talking to patients whilst assisting and encouraging them to eat.

We observed that meal times were quiet affairs. Patients on special diets are identified by a pink menu however the hospital does not routinely use red tray system. Medical staff adhere to protected mealtimes or are gently reminded if they do not.

On one ward all patients were given the opportunity to have their hands cleaned with antiseptic wipes prior to eating. People were offered a napkin and clothes were protected, whilst on the other ward there was no evidence of hand wipes being available and we were told that plastic aprons would be used to protect patient's clothing.

People were observed receiving the help they needed at meal times and staff also encouraged people to try to help themselves as part of their recovery. This help was given in an unhurried way and some people had up to 30 minutes of one to one help to ensure they had as much of their meal as they felt able. Staffing was arranged so

that as many staff as possible were available to help at mealtimes. In one bay we observed that at one point there was one to one care for all five people. However it was seen that one patient had to wait 20 minutes before staff arrived to feed them. During this time the plate had been left uncovered.

We were told that some wards have a house keeper who plays a key role in offering extra assistance at mealtimes and in helping people to make meal choices. This role complements the role of other staff on the ward at mealtime offering additional assistance and filling in file notes. This person had received training in assisting people with meals and in the nutritional care of the elderly. On the ward where there was a housekeeper she was observed prompting and encouraging people to eat and drink. Domestic staff told us that on wards where there was no house keeper the amount of food wastage was higher.

One lady asked to sit in a chair for lunch but was told that there weren't enough chairs of the specialist kind she would need. When we brought this to the attention of the ward sister we were told that a number of chairs had been sent away for cleaning and this would not usually be a problem. However in the main we saw that patients were assisted to sit correctly to enable them to eat but this could be hampered by shortage of space and adaptable chairs.

We observed that drinks for patients on the wards were dispensed from a drinks machine with patient's being given plastic cups to drink out of. Some staff said that the holders for the plastic cups weren't always washed after every use.

In interviews with staff we were told that there are special dysphasia menus available and that dietary nutritional score and weight were recorded on admission then on a weekly basis. They confirmed that patients were referred to a dietitian if required. Special nutritional supplements were prescribed if the assessment identified a need for these. Staff were made aware of patient's special needs at staff handovers and the housekeeper roll supported this. On one ward there were special dysphasia trained nurses who work closely with speech therapists to support patients with swallowing difficulties. There is a nutritional link nurse on each ward and where there is a housekeeper they attend multidisciplinary meetings and then disseminate information. We were told that speech therapists have worked with kitchen staff to ensure liquidised food is presented well.

The review of care notes supported what we were told by staff. We found food diaries for patients who required them.

In the information provided by the trust it confirmed that supportive equipment is available on all wards to assist with eating if required, including beakers with spouts, special cutlery, plate guards and non-slip mats and should any further equipment be required the Occupational Therapy department would be contacted. On the visit we did observe patients who were using special adapted cutlery and crockery.

During our visit we observed that staff were careful to check patient notes and observed instructions behind beds before engaging people in meals to ensure nutritional plans where adhered to. They were good at recording exactly what people had eaten and drunk. Where appropriate people had been assessed by

qualified staff for food diary's and swallowing care plans that had been set up by Dysphasia Trained Nurses and Speech and Language Therapists. Instructions advised in these assessments were observed to be followed by staff in practice.

On review of care plans we found that all patients had had a nutritional assessment using a recognised tool. There was evidence of patients being weighed weekly. Dietetic referrals were recorded and the dietitian's advice following assessment was also reported. The trust's web site informs patients of the time meals are served on the wards. Sample menu's can also be found.

In the information provided by the trust it confirmed that menus are prepared to ensure balanced diets are available and are coded to indicate the appropriate dietary information. Food is prepared in line with Food Safety Act (1990) which is monitored by environmental health checks, and that the admission booklet explains the mealtimes and catering facilities available. There are a variety of special menus available that take into account cultural and religious requirements such as Halal or vegan menus. Delivery of meals is reasonably spaced out, however at any time the snack boxes and out of hours service can be utilised. All ward areas have food provisions which are kept on the ward for example soup, cereal and bread as well as having access to the out of hours services.

The trust also offer patient information leaflets so that patients can make dietary choices in relation to their conditions for example, information for newly diagnosed diabetes, eating for a healthy heart and healthy eating for children. Laminated menus have been printed at larger size to facilitate reading and introduced to critical care areas. The information given allows the patient to make informed choices when selecting food from the menu.

During our visit we observed that the menu was bright, colourful with a good variety and choice. Specialist diets were also well catered for, and were labelled to help people choose. We saw that one person was struggling with the meal ordered and staff ordered her something else, which was brought up from the kitchens very quickly. The completed menu choice was available on the tray when the meal served to the patient.

However due to layout of bays, patients who were nil by mouth were sat very close to patients who were enjoying their lunch. In the information provided by the trust they highlighted that they are reviewing guidelines to support nursing staff to ensure patients are fasted for the minimum time required and offered nutrition within agreed timescales.

Staff confirmed to us that they had access to snacks for patients available in the kitchen on the ward. The housekeeper confirmed that she uses picture card menus for people with limited communication. She would also sit and read the menu to people. She has arranged for peoples religious and cultural needs to be meet.

Our judgement

The trust ensures that people who use services are supported to have adequate nutrition and hydration, by encouraging and supporting people and providing choices of food and drink to meet their diverse needs.

Overall we found that Cumberland Infirmary was meeting this essential standard.

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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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA