# Dignity and nutrition for older people

## Review of compliance

**Oxford Radcliffe Hospitals NHS Trust**
**John Radcliffe Hospital**

| | |
|---|---|
| **Region:** | South East |
| **Location address:** | John Radcliffe Hospital<br>Headley Way<br>Headington<br>Oxford<br>OX3 9DU |
| **Type of service:** | Acute services |
| **Publication date:** | July 2011 |
| **Overview of the service:** | The John Radcliffe Hospital is the largest hospital of the Oxford Radcliffe Hospitals NHS Trust. It was opened in the 1970s. It provides acute medical and surgical services, trauma |

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| | and intensive care. The John Radcliffe Hospital houses the Children's Hospital which opened in 2007, the Oxford Eye Hospital, the Oxford Heart Centre and the Women's Centre which delivers around 5,500 babies each year. It is also Oxfordshire's main accident and emergency site.<br><br>The trust is one of the largest acute teaching hospital trusts in the country. There are a total of 1372 inpatient beds and the trust had 155,560 admissions in 2010/11. The trust employs over 10,000 staff and has an annual budget of £614 million. The John Radcliffe hospital is situated in Headington, about three miles east of Oxford city centre. |

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

## What we found overall

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

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

## Why we carried out this review

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

## How we carried out this review

We reviewed all the information we held about this provider, carried out a visit on 16 May 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.

The inspection teams were led by CQC inspectors and were joined by a practising, experienced nurse. The inspection team also included an 'expert by experience'. This is a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective. This inspection was also shadowed by a senior member of the CQC's staff. During the course of the day, the inspection team spoke with nine patients, three relatives and nine staff from different disciplines.

## What people told us

Patients we spoke to at the John Radcliffe Hospital were complimentary about the staff. Comments included "excellent, couldn't be better", "if they can't do something right away, they will always come back" and "this place is second to none".

Patients felt that their privacy was respected and the process of care had been explained to them. Some patients commented that staff sometimes provided care without asking them if it was acceptable first.

Information provision was variable. On one ward patients were given leaflets about the hospital while one another, patients commented that they hadn't received any information but had 'worked it out with their relatives'. Some patients on the stroke ward outlined that they had not had a chance to adequately discuss their treatment with clinical staff.

Patients stated that there was enough choice on the menu. Views of the quality of the food were mixed. On one ward we visited patients were generally satisfied with the food. However, on another ward, patients commented that the food was 'terrible' and 'awful'. Patients commented that they received the support they required to eat and drink.

## What we found about the standards we reviewed and how well the John Radcliffe 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 John Radcliffe Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

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

## Action we have asked the service to take

We have asked the provider to send us a report within 10 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

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

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

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

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

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

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

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

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

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

## What the outcome says

This is what people who use services should expect.

People who use services:

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

## What we found

**Our judgement**

**There are minor concerns** with outcome 1: Respecting and involving people who use services

**Our findings**

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

During our visit, we interviewed nine patients and three relatives at the John Radcliffe Hospital. Prior to making the visit, we looked at information we hold on the hospital and the trust including the Patient Environment Action Team assessment and patient survey results. We also reviewed further information the trust provided.

On the acute general medical ward, all of the patients we spoke with were satisfied with the care provided. They were, without exception, complimentary about the staff. Comments included ‘excellent, couldn’t be better’, ‘if they can’t do something right away, they will always come back’ and ‘this place is second to none’. Patients on the stroke ward commented that the staff were pleasant and treated them with respect. Most patients said that they had been asked what name they would like to be called.

Patients felt that their privacy was respected and they had not been embarrassed during their stay. However, some patients we talked to on this ward, said that staff sometimes conducted aspects of care such as checking their blood pressure without

explaining what they were doing. One relative outlined that ‘he [the patient] was given no warning that his blood pressure would be taken which disturbed him and made him panic’.

On the stroke ward, patients commented that the general process of care had been explained to them and they had had a chance to discuss their treatment. Others, however, commented ‘nothing has been explained so far’ and ‘I have been here for two weekends and they haven’t explained fully why I am here’. One patient commented ‘I have been moved around wards three or four times and I don’t know why’.

The relatives of patients on the stroke ward outlined that they had been involved in decisions and support for their relatives. On the acute medical ward, patients felt they were well informed about their care and treatment and said they knew who to ask if they had any queries or concerns. One doctor was seen to remain with a patient for a lengthy period after the ward round to further discuss the details provided by the consultant. We spoke to two patients who were being discharged on the day of inspection. Both felt that the nursing and medical staff had kept them well informed during their stay and had discussed their discharge plans with them.

Patients on one ward had been provided with information and leaflets. On the stroke ward all patients we asked said that they had no information about the facilities at the hospital. Some stated that they or their relatives had ‘worked this out’.

The inpatient survey (2010) was returned by 410 patients. This survey gathered patient feedback across the whole trust and results are benchmarked against other trusts. Results show that the trust scored ‘about the same’ when compared to other trusts. The trust scored:

- 7.4 out of 10 for how involved patients felt in decision making about their treatment.
- 8.1 out of 10 for whether they had been given enough information about their treatment and care and
- 9.4 out of 10 for whether they had enough privacy when being examined or treated.
- 6.3 out of 10 for whether family or someone else close to them having enough opportunity to talk to a doctor if they wanted.

In the outpatient’s survey (2010), patients that responded rated the trust 9.4 out of 10 for being treated with respect and dignity and 9.5 out of 10 for having enough privacy for clinical discussions. The trust’s annual Patient Environment Action Team (PEAT) assessment was completed in February 2011. This was an annual assessment of non clinical aspects of care such as the environment, food and privacy and dignity for healthcare sites in England that had more than ten inpatient beds. The self assessment rated the hospital highly for addressing patient modesty, dignity and respect.

**Other evidence**

During our visit, staff were observed ensuring that patients' privacy was respected. Curtains were drawn and patients were covered. Staff commented that they dressed some patients in their own clothes rather than hospital gowns if they are confused, to ensure that their dignity was maintained. Both of the wards we visited had rooms available for private conversations between staff and patients, relatives or carers.

On the stroke ward, some staff were observed speaking to patients in a kind and reassuring manner and took time to ensure that patients were comfortable and their needs were being met. However, some contact observed between staff and patients related to tasks and these were often performed with very little interaction with patients, including when they were being supported to eat and drink.

On the acute medical ward, whilst staff interaction with patients was on the whole kind and respectful, there was, at times, a lack of attention to detail with aspects of care. One patient was visibly cold because of an open window in the bay area. This patient had placed his blankets over his head. Although there were staff in the vicinity, no one appeared to have noticed. Interaction with two patients with complex needs, one of whom had dementia, was observed to be very limited over the period of four hours that the inspection team were visiting.

The trust provided evidence of a programme that had been recently run to increase staff awareness of the fundamental standards of care on a ward by ward basis. This included an emphasis on privacy and dignity. On the two wards we visited, two staff reported that they had undertaken customer care e-learning training (learning via electronic media such as the internet). The trust informed us that 67 staff in this clinical directorate had completed the training at the time of the visit. The trust provided evidence of a training presentation entitled 'Championing dignity for the Older Person' but it was not clear who had attended this training. Sixteen registered nurses had attended a study day on care of older adults that included sessions on dementia, the Mental Capacity Act and dignity and end of life care.

Same sex accommodation was found to be adhered to on both wards we visited. The stroke ward we visited was same sex, but had single sex bays. Of the four toilets, two were permanently designated as female. The other two toilets had signage which allowed designation to be altered according to the specific needs and location of male and female patients on the ward. In the inpatients survey for 2010, the trust scored well in relation to single sex accommodation and bathroom areas.

During our visit we found poor response times to call bells. While being interviewed one patient used her bell and waited 20 minutes for a staff member to come and help her move back into bed as she was uncomfortable. On at least four occasions patients called out for assistance, but were not responded to promptly by the staff. On the stroke ward, patients commented that they often had to wait when they rang their call bells. They commented 'I have rung my bell at night and they take no notice, they don't like it when I call them' and 'sometimes I wait a long time'. On the acute general ward, the majority of call bells in three of the bays were in the holders and out of the patient's reach. We observed patients calling out to staff and being

ignored. In the 2010 inpatient survey, patients rated the trust 6 out of 10 for 'the call bell being responded to quickly if they used it'.

Both wards we visited during the inspection were busy and senior staff commented that two staff members were off sick and had not been replaced. They were however, meeting the acceptable minimum staffing requirements.

Staff outlined the process for ensuring that patients' diverse needs and preferences were identified. Initial assessments and detailed histories were taken for all patients. One senior staff member admitted that 'we could be better at noting patient's preferences'. A sample of patients' records were reviewed during the visit. These showed that patients' preferences such as their name was recorded. There was a clear chronology of their treatment on the history sheet. Patients' ability to make decisions was not always recorded.

Staff outlined that they promoted patients' independence through giving them choices, such as showering rather than bed baths. They added that 'this was not always possible'. On the stroke ward, the therapists outlined how their involvement aimed to increase patients' abilities and independence. They also commented that they included relatives in their work where possible. Medical staff we spoke to outlined that communication was vital and that discussions and decisions were always recorded in detail. A review of a sample of patient records showed that there was documentation of discussions and decisions made with patients and relatives.

On the stroke ward, there was no information besides peoples' beds. The hospital has a new booklet called 'Your stay and planning to leave hospital' but it had not yet been issued to patients. General ward leaflets were displayed on notice boards. On the stroke unit, there was a board with information about returning to driving after a stroke.

The trust had a range of methods in place to collect patients' views. This included patient questionnaires given out at ward level. The trust also use patient held devices to get immediate feedback as well as the Patient Advice and Liaison Service (PALS). The trust provided evidence of consideration of patient feedback at board meetings, quality committee meetings and at ward level. These included actions taken as a result of feedback from patients in specialty areas (2010-11).

**Our judgement**

Patients at the John Radcliffe Hospital felt their privacy was respected. They were complimentary about staff on the wards. On the whole, staff were kind and respectful to patients. Details of discussions with patients and relatives were recorded in care plans and relatives were involved in decisions and support for patients where appropriate. The hospital collected patients' views and had a process in place to identify improvements that needed to be made. However, some patients reported that they did not receive adequate information about their treatment and care. There was also limited interaction and communication with patients by some staff members and a lack of care taken with some patients. Staff did not always ensure patients' care needs were met in a timely way.

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

# Outcome 5:
# Meeting nutritional needs

## What the outcome says

This is what people who use services should expect.

People who use services:

- Are supported to have adequate nutrition and hydration.

## What we found

**Our judgement**

**There are moderate concerns** with outcome 5: Meeting nutritional needs

**Our findings**

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

Patients we spoke to commented that there was enough choice on the menu and that staff would find an alternative if they didn't like the food that was on offer. Staff commented that if patients need help with choosing their meal, they would receive this. Copies of the menus showed that there was a good choice of food, including the ability to meet different cultural and dietary requirements. The hospital provided snack boxes for those patients who were hungry or who had missed a meal.

Patients we spoke to commented that there was always enough food. The patients on the acute general medical ward were generally satisfied with the food, although some commented that it could be improved, in particular, the desserts. On the stroke ward, the majority of patients were nil by mouth. However, on this ward patients who were eating generally commented that the food was 'terrible' and 'awful'. One patient commented that mealtimes 'were ok, apart from the food'. Another patient commented 'I would like to have different food, but it is a hospital, so I don't expect it to be great'.

During our visit, the soft moist food provided to patients did not look appetising. Two staff members commented that it was not good. One of these had been involved in efforts to improve the soft moist diet for patients. The trust informed us that the soft moist diet had been withdrawn in February 2011 because some of it could not be made fine enough and was therefore unsafe. An 'off the shelf' alternative solution

had not been readily available. The trust reported that they had worked with their supplier to improve the options and that these had been nutritionally approved by the dieticians in early May 2011. This had not yet been introduced at the time of our visit.

In the inpatient survey (2010), completed by 410 patients across the trust, the quality of food was rated 5.1 out of 10. This was the 'about the same' when compared to other trusts. Patients scored 8.8 out of 10 for choice of food and 6.9 out of 10 for whether they were given enough help from staff to eat their meals, if they needed it.

The trust's annual Patient Environment Action Team (PEAT) assessment was completed February 2011. This was an annual assessment of non clinical aspects of care such as the environment, food and privacy and dignity for healthcare sites in England that had more than ten inpatient beds. The scores were achieved through self assessment and verified by the National Patient Safety Agency. The hospital scored excellent for food. This included assessment of choice, availability and quality of food. The trust also collected monthly food service scores by ward and these were shown to be consistently high.

**Other evidence**

Patients on the stroke ward we visited were assessed when they were first admitted to determine if they had swallowing difficulties. Staff outlined that nursing staff had been trained to undertake these assessments. In addition, the trust had trained a speech and language therapy assistant to perform the screening test where necessary. Staff outlined that if the patient 'failed' the screening assessment (therefore indicating potential swallowing difficulties) a more in-depth assessment was conducted by a registered speech and language therapist. Data we reviewed showed that, in the last quarter, 85% of patients who required a swallow assessment received this within 24 hours of admission.

Patients on the stroke ward also received care from speech and language therapists and dietitians. Once swallowing screening assessments were carried out on patients on the stroke ward, the nutritional status for patients was put on a board above their bed. This stated whether they were nil by mouth, on a pureed diet or eating normally. Therapy, nursing and medical staff commented that they regularly reviewed patients' ability to eat and drink. Records showed that patients on this ward were weighed weekly. However, the Malnutrition Universal Screening Tool (MUST) held in patients' records was not always completed. This is a five step process to identify adults who are either malnourished or at risk of being malnourished. On the acute medical ward, a review of records showed that the MUST nutritional assessments were either blank or had not been fully completed.

A review of records also showed that fundamental systems were not in place for documenting different aspects of nutritional care. Patients' dietary and fluid intake was not regularly recorded on either ward we visited. Senior ward staff acknowledged that while they were sure that staff were providing the care that was required, documentation of care required improvement. This included recording fluid and dietary intake. Observations of care, during the course of the visit, showed that patients who needed support with fluids did not always have drinks within their reach. This was compounded by call bells not being in reach for patients on one

ward. One patient who could not drink independently was not seen to be offered a drink over a 4 hour period, other than at lunchtime.

The trust provided some training for staff on nutritional care. The stroke ward had an education session every week and this had recently included a session on nutrition and fluids. The therapy staff commented that they continuously work with the junior medical staff, nurses and carers on aspects of nutritional care. This included communication and dysphasia training. The ward outlined that they are working to use picture charts to improve communication with stroke patients. Staff on both wards we visited had good access to specialist advice. Figures provided by the trust showed that 83% of relevant staff had attended mandatory food hygiene training.

The trust had a red tray system where patients who require assistance with eating and drinking and additional monitoring, had their food served on a red tray. The system aimed to prompt staff to ensure the patients received the support they required. It also aimed to assist catering staff when serving and collecting food. On one ward we visited, the system was not in use on the day. On the other ward we visited, the system was not working effectively. Some patients without a red tray clearly required help and struggled to open packages and feed themselves. Another patient who had a meal on a red tray did not appear to require any assistance.

Most patients were not offered the chance to wash their hands before mealtimes and only some patients were offered napkins. The PEAT assessment conducted in February 2011, stated that the use of hand wipes across the trust was inconsistent. Minutes of the nutrition advisory board in May 2011 also identified this as an issue.

On the acute medical ward, patients requiring help to eat were generally supported by the staff. However, this was not always conducted in an appropriate manner. One staff member was observed to stand over a patient while assisting them to eat. This looked particularly uncomfortable for as the patient was seated much lower in a chair. Another patient was observed eating a salad, but was unable to remove the remaining cling film and did not get help from staff as they passed.

On the stroke ward, the majority of patients were nil by mouth. We observed some patients on both wards receiving help in a supportive and appropriate way. Other staff however, did help patients but seemed to be disengaged in the process and there was a lack of urgency in ensuring that patients could eat their meals while they were still warm. We observed five examples of a delay between patients having their food opened and receiving the help they required.

The trust had a ‘protected meal time’ policy in place. This policy seeks to ensure that mealtimes are uninterrupted by things such as doctors’ ward rounds, tests or visiting. However, it was not adhered to on either of the wards we visited during lunch time. Some staff on the acute medical ward were seen attending to non-urgent duties during the lunchtime period, such as making up beds. We were told that the housekeeper on both wards was not working on the day of our visit. One staff member we spoke to also had concerns about breakfast time and the number of professionals who visited the ward very early, potentially disrupting the patients’ meals. The Patient Environment Action Team assessment scores from February 2011 show that protected mealtimes were not well implemented at the John

Radcliffe Hospital.

The trust provided evidence that they conducted an audit of nutritional care four times a year. The nutrition advisory group minutes from May 2011 outlined a number of issues that had been identified as needing to be addressed. These included the inconsistent use of hand wipes, lack of preparation of patients for their meals, the timing of food delivery, problems with assistance required for patients and clarity of responsibilities with this. The minutes showed that staff had been allocated to review the audit results.

**Our judgement**
Patients have an adequate choice of food and different cultural and dietary requirements are catered for. There were mixed comments on the quality of the food. Some patients found it satisfactory and others felt it was of poor quality. In the last quarter, 85% of stroke patients were screened for swallowing difficulties within 24 hours of admission at the John Radcliffe Hospital. However, we found that fundamental systems were not in place for recording different aspects of nutritional care such as patients' dietary and fluid intake. Malnutrition assessments were not conducted for all relevant patients. The red tray system to enable patients to receive appropriate support to eat and drink was not working effectively on the wards we visited. While patients received support to eat and drink, this was not always provided in an appropriate or timely way. The hospital had a policy on protected mealtimes, but we found that this was not fully implemented on the wards we visited.

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

# Action
we have asked the provider to take

## Improvement actions

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

| Regulated activity | Regulation | Outcome |
|---|---|---|
| Treatment of disease, disorder or injury.<br>Assessment or medical treatment of persons detained under the Mental Health Act 1983.<br>Surgical procedures.<br>Diagnostic or screening procedures. | 17 | 1 |
| | **Why we have concerns:**<br>Patients at the John Radcliffe Hospital felt their privacy was respected. They were complimentary about staff on the wards. On the whole, staff were kind and respectful to patients. Details of discussions with patients and relatives were recorded in care plans and relatives were involved in decisions and support for patients where appropriate. The hospital collected patients' views and had a process in place to identify improvements that needed to be made. However, some patients reported that they did not receive adequate information about their treatment and care. There was also limited interaction and communication with patients by some staff members and a lack of care taken with some patients. Staff did not always ensure patients' care needs were met in a timely way. | |

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

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

The provider's report should be sent within 10 days of this report being received.

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

## Compliance actions

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

| Regulated activity | Regulation | Outcome |
|---|---|---|
| Treatment of disease, disorder or injury.<br>Assessment or medical treatment of persons detained under the Mental Health Act 1983.<br>Surgical procedures.<br>Diagnostic or screening procedures. | **14** | 5 |
| | **How the regulation is not being met:**<br>Patients have an adequate choice of food and different cultural and dietary requirements are catered for. There were mixed comments on the quality of the food. Some patients found it satisfactory and others felt it was of poor quality. In the last quarter, 85% of stroke patients were screened for swallowing difficulties within 24 hours of admission at the John Radcliffe Hospital. However, we found that fundamental systems were not in place for recording different aspects of nutritional care such as patients' dietary and fluid intake. Malnutrition assessments were not conducted for all relevant patients. The red tray system to enable patients to receive appropriate support to eat and drink was not working effectively on the wards we visited. While patients received support to eat and drink, this was not always provided in an appropriate or timely way. The hospital had a policy on protected mealtimes, but we found that this was not fully implemented on the wards we visited. | |

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

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

The provider's report should be sent to us within 10 days of this report being received.

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

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

# What is a review of compliance?

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

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

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

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

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

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

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

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

## Dignity and nutrition reviews of compliance

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

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

The inspection programme follows the existing CQC methods and systems for compliance reviews of organisations using specific interview and observation tools. These have been developed to gain an in-depth understanding of how care is delivered to 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<br>Citygate<br>Gallowgate<br>Newcastle upon Tyne<br>NE1 4PA |