Dignity and nutrition for older people

Review of compliance

Homerton University Hospital NHS Foundation Trust **Homerton University Hospital**	
Region:	London
Location address:	Homerton Row Hackney London E9 6SR
Type of service:	Acute services
Publication date:	May 2011
Overview of the service:	Homerton University Hospital provides a range of hospital-based acute healthcare and maternity services to people in Hackney, the City of London and neighbouring London boroughs. It is a relatively new hospital, built in 1986, and employs over 2000 staff.

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

What we found overall

We found that Homerton University Hospital 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 team was 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.

We reviewed all the information we hold about this provider (for example, national patient survey results and indicators of hospital performance), we carried out a visit on 16 March 2011, observed how people were being cared for, talked to people who use services and staff and looked at a sample of records of people who use services.

During our visit, we spent time on two wards:

- Aske ward – care of older people and
- Graham ward - stroke rehabilitation

We selected these wards because they were likely to be used by older people needing different levels of support. We arrived on the wards at 9:30am as breakfast was finishing and stayed until after lunch. We interviewed five patients and four of the nursing staff during this time. The interviews, together with our observation and case

review of records, allowed us to explore the experience of people on these wards in some depth.

The stroke rehabilitation ward was very busy on the day we visited with many health professionals (physiotherapists, speech therapists, physicians and so on) providing care to people during the course of the morning. Aske ward was quieter. Many of the patients on this ward had complex health conditions including dementia and needed a lot of support from the nursing staff.

Both the wards we visited were arranged as four six-bedded bays set out in an L-shape around a central nursing desk. There were also four single rooms on each ward. Each bay was single-sex. The toilet and shower facilities (clearly marked as male or female) were located opposite each bay. Each patient had a side locker with hanging space and a lockable drawer in which to keep their personal belongings. In design and size, these wards were fairly typical of the wards at Homerton Hospital. The ward environment was very clean and appeared to be well equipped and maintained.

What people told us

People were positive about the Homerton University Hospital and praised the staff as caring and hard working. Patients told us that staff treated people with kindness, for example when helping people to eat. People had generally been given enough information but medication was sometimes an area where people wanted to know more. People said that they and their families had been involved in decisions and they had received helpful support from professionals. People felt able to raise any issues and said that staff had always listened even if the problems were not fully resolved.

Most of the people we spoke to said there was a choice of meals and the food was good. One person did not find the hot meals appetising but could find things they liked from the cold options. At the time of our visit, patients reported a lack of choice of kosher meals. One patient said they had to wait too long for lunch and we also observed this. Patients said that staff checked they had enough to eat. Two people mentioned that they were weighed regularly and their fluid intake was being checked. One of the patients we spoke to had initially been admitted to the ward after tea time. The nurses had brought them some food so they did not go hungry. None of the other patients we interviewed had missed a meal.

What we found about the standards we reviewed and how well Homerton 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
Homerton University Hospital recognised and supported people's individual needs, independence and cultural preferences. People and their families were involved in decisions about their care. People's views were sought about the service more generally although staff could not always explain what improvements had been made

as a result. We observed some instances when staff could did not fully respect patients' dignity, for example, by not talking to patients when checking bedside charts, but these were the exception.

- Overall, we found that Homerton University Hospital was meeting this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs
The trust provided people with information about meals and people were usually but not always offered choices. The people we spoke to were generally positive about the food. The trust was not fully promoting people's independence in relation to choosing food, eating and drinking. On one of the wards we visited, some people could not start their lunch until around 1:30pm because there was limited capacity to heat meals on the ward.

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

Action we have asked the service to take

We have asked the provider to send us a report within 28 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

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
The trust as a whole had declared itself compliant with the national requirement to eliminate mixed-sex accommodation.

The most recent national survey of adult inpatients was undertaken in 2010. The trust scores for dignity and privacy were generally worse than other hospital trusts. However, the Patient Environment Action Team inspected the trust in 2010 and scored the hospital as ‘excellent’ for modesty, dignity and respect. The national survey of NHS staff (2010) showed that this trust was in the top 20 per cent of hospitals in England for the proportion of staff recommending their hospital as a place to work or receive treatment.

When we arrived on the wards as part of our inspection, some patients had not yet had a wash or eaten their breakfast. This was because the ward staff did not rush people if they were still sleeping. We saw lots of examples of staff talking politely to the patients, speaking quietly to maintain people’s privacy and explaining what they were doing. For example:

- The healthcare assistant cleaned people's tables after breakfast. She explained what she was doing to people who were awake but did not disturb people who were sleeping
- Nursing staff took the time to say good morning and chat to patients when they came on duty
- The staff always used the curtains to protect people's privacy, for example when they were discussing or providing treatment, when they were giving medication or when people were having a wash at their bedside. Staff pegged a 'do not disturb' sign to the curtain and people always asked before entering an area where a curtain was closed.
- When one of the medical teams visited Aske ward, the doctors introduced themselves very clearly and asked people what they would like to be called.
- A nurse asked permission before going into a drawer to get a personal possession for the patient.

There were instances where we saw staff making observations to colleagues across the heads of patients, saying in one case '*She's very sleepy'* about one patient who had not eaten their breakfast. A nurse praised an older patient in a way more appropriate for a child, saying *'Good girl'*. Occasionally people came onto the ward (for example, a pharmacist checking medication charts) without talking to patients. These instances were the exception however. Throughout our observation, staff generally treated people with kindness and respect and worked hard to maintain people's privacy.

The patients we spoke to were generally happy with the way staff cared for them:

> '*They are very patient and caring. They mean the best, although they don't always express it.'*
>
> '*Some are very caring. Some are just doing it as a job and are OK. Most of them are very good*'
>
> '*Yes – very good – yes. All I can say is the nurses work hard*'

The stroke rehabilitation ward was extremely busy for much of the morning and staff were focused on the tasks they needed to complete. Even so, we saw many instances of staff speaking to patients and responding to them as needed.

Some of the call bells were placed out of patients' reach on both the wards we visited. This was sometimes because these patients were not able to use them. Patients and staff did not think that access to call bells was an issue as staff were accessible in each bay and patients were readily able to ask or show that they needed assistance.

> For example, one person with dementia became anxious, got out of bed and approached a nurse. The nurse welcomed the patient, answered her questions and asked if she would like to sit with the nurses at the desk. The patient was reassured and felt able to return to bed.

A number of patients on both wards had high care needs and the staff appeared to

know them very well. This was also commented on by the patients we spoke to:

> *'They are very caring for those that are completely helpless. They feed them and they are very kind to them.'*

We asked patients if staff responded to their needs quickly and they said the staff always came if they called.

We saw lots of examples on the stroke rehabilitation ward of staff encouraging people to be as independent as possible, feeding themselves, brushing their teeth and walking with the support of a multidisciplinary team of staff, including physiotherapists, occupational therapists and speech and language therapists among others.

The patients we spoke to generally felt that they had been able to make informed choices. However, medication was one area where some people wanted more information:

> *'I would like more information about side effects. Don't want to be experimented on. … Sometimes they are almost frightened to ask me – I can get bolshi. But I really do want explanations. They do answer when they see what I am asking.'*

> *'Still unsure about medication and aftercare.'*

One person reflected that it was easy to lose confidence when being cared for by more than one medical team. It was not so much that information was not given to them but that from the information presented, it was not apparent who was taking the lead for their clinical care and how this was being coordinated:

> *'Hospital doctors come in and explain. And then another comes and says something different. Three doctors in the course of one day saying "my decision is" but they don't seem to talk to each other. ... You are asked for the result of x-rays and what other doctors have said. ... It is isolating. It is a dignity issue.'*

None of the patients we spoke to had been asked for their feedback. We did see evidence of feedback mechanisms on both wards and these are described below.

Other evidence

The nursing staff (both senior and junior) emphasised the importance of talking and listening to all patients from the point of admission onwards to ensure that their wishes were understood and respected. The staff had access to interpreters and advocates as well as hospital specialists (for example, psycho-geriatricians). Staff said that they worked closely with relatives, for example, when people were cognitively impaired and also looked for non-verbal cues from patients. Staff were able to give us examples of decisions made with patients and their families (for example to move into a care home after discharge).

Both wards we visited held ward meetings to reflect on practice. Staff identified dignity and respect as themes that ran across all mandatory nurse training courses and staff induction. Annual dementia awareness training was available for staff with additional training for staff working on relevant wards. Trust-wide updates and initiatives on these topics were communicated by email. These messages were displayed in the staff room.

People's preferences and choices were recorded for example, at the nurses' desk. There was a large white board there on which patients' preferences were marked. There were also smaller whiteboards over each bed where, for example, people's preferred form of address could be recorded.

We asked staff how well they thought they did in respecting people's dignity and privacy:

> *'80% of the time it's good. Sometimes doctors not communicating and interrupting care delivery. Lack of awareness with some of the medical students about protected meal times'*
>
> *'We are able to accommodate people's cultural preferences. Dietary requirements are recorded in the kitchen. There is a hospital-based religious service or people can access their own from the community. We try and provide same gender care if that's important'.*

Senior staff said that their role involved setting clear standards around dignity and respect. They observed practice on the wards and would intervene by speaking to staff if necessary and through further training. Junior staff were clear that they would raise any concerns with the ward sister or matron.

Both wards were taking part in the 'Time to care' initiative (developed nationally by the NHS Institute for Innovation and Improvement).Both wards had posters and leaflets clearly which informed patients about the aim of the initiative and inviting them to ask members of staff about it.

Many patients were admitted with dementia alongside their acute health condition. This was viewed as an area for development across the trust. The ward sister told us that the trust was investing in three specialist dementia workers to join Aske ward. The trust was also running a project looking at the use of biography as part of the assessment process for older patients and their carers.

The hospital gives electronic recording devices to a sample of patients to feedback their experience (electronic patient tracking). We saw the feedback equipment on the wards but did not see anybody using a device when we visited. Staff were aware of the system and were able to point to recent results which were displayed. Staff also mentioned other mechanisms such as patient surveys and a ward-based suggestion box. We asked staff what changes had been made as a result of patient feedback. One person said the ward had reinforced the need to place bedside tables and call bells in patients' reach but the other staff we interviewed were unsure. There was little evidence that the ward teams took ownership for acting on feedback from patients.

Our judgement
Homerton University Hospital recognised and supported people's individual needs, independence and cultural preferences. People and their families were involved in decisions about their care. People's views were sought about the service more generally although staff could not always explain what improvements had been made as a result. We observed some instances when staff could did not fully respect patients' dignity, for example, by not talking to patients when checking bedside charts, but these were the exception.

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 minor concerns with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The trust had recently introduced a new catering system. The food was delivered to the ward already plated. Hot dishes were then reheated in microwave cookers on the ward and served as they became ready. On Aske ward, the staff were able to heat up to three meals at a time. This meant that it could take up to an hour to serve everyone.

The trust operated protected meal times for patients. This means that patients should not normally be interrupted during this time by staff or visitors.

The most recent national survey of adult inpatients was undertaken in 2010. The trust's results for the support it gave to help patients to eat were worse than other hospitals. This is something we looked at during our visit. There were patients on both wards who needed support with eating and drinking. Staff used a red/blue tray system to identify people who needed support or longer to eat their meal. There was a board at the nurses desk which clearly identified which patients needed support or had other dietary needs or preferences. Volunteer helpers came on to Aske ward to help people with lunch and this seemed to work well.

On the day we visited:
- Food and drinks were all within patients' reach and patients were sitting comfortably. Food was cut up and packets opened as needed.
- Staff and volunteers explained what they were doing and gave people a

- Staff and volunteers were focused on the people needing most care (with red trays) but responded positively to other patients' requests.
- Most of the patients ate something but some needed encouragement which they received, 'Did you like it?' 'Would you like to try some yoghurt?' 'See if you can eat a little'.
- We saw one person with dementia who also had some challenging behaviours being supported to have their lunch. This was done very patiently and the staff member clearly explained what was happening.
- Some relatives attended during lunch time to support their family members. The ward staff spoke to them and ensured they were happy to do this and did not need assistance.

But we saw several examples when staff stood over patients while feeding them. In one case, this occurred as a relative in the same bay was helping their family member to eat. The relative sat next to the patient and chatted while helping them. It would help create a more relaxed approach if staff sat down to help people eat.

We did not see any plate guards or adapted cutlery in place which could have assisted some people. On Aske ward, most patients were provided with water in beakers with sipping lids although we observed that some of these people were able to drink from normal plastic cups. We were concerned that the hospital was not fully assessing people's individual capabilities with a view to promoting independence.

The process of delivering lunch on Aske ward took around an hour on the day we visited. This meant that some people did not start eating their lunch until around 1:30pm and were uncomfortably hungry. One patient became upset about the timing: '*This is chaos. It is disgusting*'. Staff responded by saying the meal was coming but did not seem able to speed up the process for this patient.

The phased nature of lunch delivery did allow staff and volunteers time to support people who needed help as meals became ready. But after talking to staff, we were concerned that the timing issues on this ward seemed to be driven primarily by the number of available microwaves rather than consideration about patient outcomes.

Patients told us that staff checked they had had enough to eat. Two people mentioned that they were weighed regularly and their fluid intake was being checked. One of the patients we spoke to had initially been admitted to the ward after tea time. The nurses had brought them some food so they did not go hungry. None of the other patients we interviewed had missed a meal.

The 2010 national inpatient survey results for choice and quality of food suggested that the trust's performance was similar to other hospitals. The Patient Environment Action Team visited the trust in 2010 and scored the trust as 'Good' for its food – this score included both choice and quality.

The menu included some pictures but these were not really large enough to help patients who were unable to read or unable describe what they wanted verbally. Staff told us they asked patients' relatives in this situation.

There were separate menus available for people who needed pureed food (soft or textured), halal meals or kosher meals. However, two of the patients we spoke reported having little real choice of kosher meals. Comments on choice included:

> *'There is enough choice. If don't eat dinner – am offered a sandwich.'*
>
> *'The food is nice but there's not enough choice. Kosher food - that's the issue for me. No-one has ever given me a menu. Someone came originally to ask what food I wanted. They had a list. That's no use for any of these people (patient indicated nearby patients with cognitive problems).'*

Generally the food looked appetising, for example, the foods that had been pureed were separated on the plate (vegetables and main). Most patients who were able to eat seemed to enjoy the meals. Comments included:

> *'The hot food is always hot and there's a choice of hot drinks available. Mealtimes are a pleasant diversion… But it comes late – too late.'*
>
> *'The food is excellent. It is enough.'*

One person did not like the main meals but felt there was a reasonable choice of sandwiches as an alternative.

Other evidence

Staff told us they carried out detailed nutrition and hydration assessments when people were admitted to hospital or if their condition changed during their stay. We saw evidence in the medical notes confirming that staff had made referrals to a dietitian when they had concerns about this and that subsequent action, (for example prescribed dietary supplements) had been taken.

Staff explained that they received training on nutrition as part of their professional development, on the job, and as part of their induction at the hospital. There was specific internal training around feeding and staff had access to 'nutritional champions'.

Staff were aware of audit around nutrition standards including spot checks. The senior nurses had been involved in discussions and action planning following audit.

> *'Everyone is involved'*
> *'There's always room for improvement'.*

The hospital monitored nutritional needs in a number of ways (using notice boards, paper notes and electronic records). However, we found that the paper records were not always complete. For example, in two records, we found that entries recording what people had eaten over the previous two weeks were sporadic with no reason recorded for this. Another entry recorded that a patient needed assistance with meals but not what form that assistance should take. It is important that staff can rely on notes to be up to date and complete in order to monitor people's nutritional needs effectively.

The trust had made nutrition one of its *Commissioning for Quality and Innovation* priorities and monitored a number of specific indicators of quality under this heading:

- total numbers of patients having a nutritional assessment
- total number of patients using a Red tray when identified by ward staff
- numbers of patients answering 'yes always' to the question 'did you get enough help from staff to eat your meals' (from the electronic patient tracking system)

These indicators have been agreed with the NHS body that commissions care from the trust and are monitored by both parties. The trust shared its most recent CQUIN report with us which showed that it was achieving its targets.

Staff believed that the trust provided a real choice of food and was able to meet people's cultural and health needs. Relatives were also welcome to bring food to the ward although this could not be heated. The staff were positive about the new catering system and thought this had noticeably improved the choice and quality of food for patients.

> *'I like the new catering system. It offers people a wide range of choices. Can meet cultural needs and can always go to the kitchen and get another meal if needed. There is soft food if needed and healthy diets for people with diabetes.'*

One senior nurse reflected that there was room to improve the help given to patients with high care needs to choose their own meals. In practice staff tended to rely on relatives. '*In theory it is good. In practice not always so good. Maybe need a picture guide and to spend more time in helping people choose.*'

Our judgement

The trust provided people with information about meals and people were usually but not always offered choices. The people we spoke to were generally positive about the food. The trust was not fully promoting people's independence in relation to choosing food, eating and drinking. On one of the wards we visited, some people could not start their lunch until around 1:30pm because there was limited capacity to heat meals on the ward.

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

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	14	5 Meeting nutritional needs
	Why we have concerns: The trust was not fully promoting people's independence in relation to choosing food, eating and drinking. On one of the wards we visited, some people could not start their lunch until around 1:30pm because there was limited capacity to heat meals on the ward.	

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 28 days of this report being received.

CQC should be informed in writing when these improvement 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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