Care Quality Commission

Dignity and nutrition for older people

Review of compliance

Wye Valley NHS Trust
Hereford Hospital

Region:	West Midlands
Location address:	County Hospital Union Walk Hereford HR1 2ER
Type of service:	Acute services
Publication date:	May 2011
Overview of the service:	Wye Valley NHS Trust is the main provider of acute services across Herefordshire and parts of Wales. Hereford Hospital provides a wide range of services which includes emergency care medicine, surgery, maternity services and paediatrics. Hereford Hospital operates in a building opened in 2002 under a Private Finance Initiative (PFI), and includes a dedicated cancer unit.

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

What we found overall

We found that Hereford 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 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 3 February 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 team was led by a CQC inspector joined by two practising, experienced nurses.

What people told us

People told us that nursing and care staff generally treated them with dignity and respect, but some people felt that medical staff talked about them rather than to them. One person said "You're just told that things are happening, there's no explanation" and another told us "the doctors don't tell you what's going on".

Almost everyone we spoke to told us that they enjoyed the food provided by the hospital, and that there was plenty of choice. People told us that they could choose the portion size they wanted, although some people said that they would have preferred larger portions. People did not like the fact that the main course and puddings are served at the same time, and people told us "pudding can get cold if you don't eat your first course quickly" and "hot puddings go cold and ice cream starts to melt, as it's all served at the same time".

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

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.

Where we have concerns, we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

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

People told us that nursing and care staff generally treated them with dignity and respect, but some people felt that medical staff talked about them rather than to them. One person said "You're just told that things are happening, there's no explanation" and another told us "the doctors don't tell you what's going on". In the 2010 NHS inpatient survey, which was completed by 474 patients, patients gave the trust an overall score of 7.4 out of 10 for the provision of information. The trust scored 7.8 out of 10 for whether patients felt they received answers they could understand from their doctor. These scores were similar to other comparable NHS trusts.

We spent time observing staff providing care and support for people on three wards. Generally we saw staff responding positively to people. We heard staff explaining procedures clearly and reassuring people as they carried out the procedures. Staff were careful to ensure that privacy was respected during personal care. However, we saw one member of care staff talking to one person in a patronising manner. One

person told us that some staff “talk to me as if I’m daft” and said “they probably think I’ve lost my marbles, because I’m old”. Overall, in the inpatient survey, the trust scored 8.2 out of 10 for whether patients felt they were treated with dignity and respect. This score was worse than other similar trusts.

We observed one member of staff supporting someone to eat their lunch. The staff member stood over the person, and spooned food into their mouth. The staff member did not engage with them, but kept talking to other members of staff.

All of the bays in the wards we visited were single sex, and the Director of Nursing showed us records of daily monitoring, so that the hospital can ensure that men and women are cared for separately.

People had call bells within reach, and we saw that staff were regularly checking to make sure people had everything they needed. Findings from the inpatient survey however, indicate that not all patients feel they get help quickly enough. The trust scored 5.8 out of 10 for whether call bells were answered quickly enough.

Patients told us that staff are careful to make sure that their privacy is maintained, and we saw that staff were careful to make sure that curtains were fully drawn around beds and that they knocked before entering single rooms.

Some people told us that they had been involved in planning their own care. One person who was due to go home praised the staff for the way they had been involved in making decisions about the support they would need when they left hospital. The person said “they don’t talk around you, they include you”. However, other people said that they hadn’t felt involved in making decisions, and one person said “you feel as though they (doctors) are talking about you and it’s something that you shouldn’t know about”. The trust scored 6.8 out of 10 in the 2010 NHS inpatient survey for whether patients felt they were involved as much as they wanted to be in decisions about their treatment and care.

Other evidence

Records showed that medical staff had discussed people’s care with them and, where people did not have the capacity to make decisions for themselves, discussions had taken place with relatives. We found evidence that records about an important assessment had not been documented as they should have been.

The Patient Environment Action Team (PEAT) assessment tool helps trust to self assess non-clinical aspects of patient care including environment, food, privacy and dignity. In February 2011 the PEAT assessment identified some areas of good practice at the hospital. For example, the use of red pegs: when curtains are drawn around the patient a red peg is hung on the curtain. This indicates that a procedure is being carried out so that people can respect the privacy and dignity of the patient.

Our judgement

People generally have their privacy respected at the hospital. However, there is some

evidence that patients' dignity is not always respected and promoted. Some patients felt that they are not adequately involved in decisions about their care and treatment.

Overall, we found that Hereford 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

The provider is compliant

with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

Almost everyone we spoke to told us that they enjoy the food provided by the hospital, and that there is plenty of choice. People told us that they appreciate the fact that they can choose the portion size, and this was especially appreciated by people with small appetites. This finding is supported by the 2010 NHS inpatient survey which was completed by 474 patients. Patients gave the trust an overall score of 8.1 out of 10 for the amount of choice of food.

During the inspection, we observed that the main course and pudding were served at the same time, and people told us that this sometimes meant that their pudding was not at the right temperature when they ate it. One person said “pudding can get cold if you don’t eat your first course quickly” and another told us “hot puddings go cold and ice cream starts to melt, as it’s all served at the same time”.

We saw that one person’s lunch was left in front of them for forty minutes, by which time the pudding, which was ice cream, had completely melted. Another person, who was being assisted to eat, had a bowl of chocolate sponge with chocolate sauce, which they began to eat thirty minutes after it had been served. A member of staff confirmed that the pudding was no longer hot.

Patients’ care records were reviewed and showed that people who are at risk of

malnutrition are referred to the dietetics department for specialist assessment of their needs. The staff we spoke to were able to explain clearly how they were meeting peoples' nutritional needs. Food intake charts had been completed in detail, so that staff had an accurate and up to date record of what people had eaten.

We saw that there were drinks available and within reach for everyone we saw on the wards. People told us that staff will happily provide hot drinks on request. Patients who completed the 2010 NHS inpatient survey rated the trust 6.9 out of 10 for whether they received adequate help with eating and drinking. This was a similar rating to that achieved by other NHS trusts.

Other evidence

The PEAT assessment for February 2011 included information that almost everyone who is admitted to the hospital has their nutritional needs assessed within 24 hours of admission.

People at risk of dehydration or with specialist medical needs all had fluid intake and output charts, and we saw that these had been completed and that the total intake and output was recorded. We saw that one person had been fed using a tube directly into their stomach. There were clear records of how much liquid food had been given. The person was beginning to eat solid food again, and staff were taking care to ensure that the person was able to swallow the food they were being given.

Staff told us that they use the food and fluid intake charts to ensure that they monitor whether patients are getting enough to eat and drink.

Our judgement

Patients' nutritional needs are generally met at the hospital and the management of hydration is a particular strength.

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	17	1 Respecting and involving people who use services
	Why we have concerns: People generally have their privacy respected at the hospital. However, there is some evidence that patients' dignity is not always respected and promoted. Some patients felt that they are not adequately involved in decisions about their care and treatment. Overall, we found that Hereford Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.	

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.

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