Dignity and nutrition for older people

Review of compliance

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<th>University Hospitals Bristol NHS Foundation Trust</th>
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<td>University Hospitals Bristol Main Site</td>
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<th>South West</th>
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<td>Bristol Royal Infirmary</td>
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<td>Type of service:</td>
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| Overview of the service:  | The provider is an acute NHS foundation trust providing services across the Bristol and greater Avon area. The trust also provides specialist care to people from across the South West Region. |

Page 1 of 25
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that University Hospital Bristol Main Site 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 5 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 joined by a practising, experienced nurse. The inspection team also included an ‘expert by experience’ – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.
What people told us

Most patients and their relatives told us that they were satisfied with the care and treatment they received at University Hospitals Bristol Main Site. They said they had been treated with courtesy and respect and that their privacy and dignity had been protected.

People told us that all staff explain and ask if it is alright before they help or provide any care. One patient said “Yes they do. They are respectful of our privacy. Yes they do always draw the curtains”. People told us that care is given in a respectful way but that they sometimes feel that some staff don’t like giving care or are shy.

We observed personal care being provided behind closed curtains including examinations and discussions with medical staff. Some of the discussions could be heard throughout the bay area on the day of our visit.

Most people told us that they had received information about the care and treatment options available to them although some didn’t feel that they had received enough information. People told us that they had not received information about the facilities available within the hospital or about what will happen when they leave the hospital. People told us that they understood the information that was given to them and that staff take time to ensure that you understand. One person said “the staff don’t really have much time to talk to you unless you need a lot of care.”

People told us that staff respond to their needs quickly enough during the day time but that at night they feel that they are short staffed and that it takes longer for somebody to come and help them.

Most people told us that they were asked what they liked to be called but that in some cases staff did not use this name to address them. One person told us that they had not been asked what they liked to be called but that it didn’t matter.
What we found about the standards we reviewed and how well University Hospitals Bristol Main Site 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 University Hospitals Main Site was meeting this essential standard.

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 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

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<th>Our judgement</th>
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<tr>
<td>The provider is compliant with outcome 1: Respecting and involving people who use services.</td>
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<table>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told</strong></td>
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We spoke to five patients during our visit. The people that we spoke with had been in the hospital for between one day and three weeks.

People told us that on the whole they were happy with the way that staff were caring for them with comments such as “They have all been really kind” and “I can’t thank them enough, most of them are very, very nice, some are not so caring.” Most people told us that they were asked what they liked to be called but that in some cases staff did not use this name to address them. One person told us that they had not been asked what they liked to be called but that it didn’t matter.

People said that they had not been asked if they wanted to be treated in a particular way but that they felt that there was no need for them to ask this or that they didn’t expect to be and that staff were very busy. People told us that all staff (nurses, physiotherapists etc) explain and ask if it is all right before they help or provide any care (e.g. taking blood pressure or providing personal care).
When asked if they had been embarrassed or uncomfortable during their stay the majority of people said no. They said they had been offered the choice of having a male or female nurse to attend to care needs. One patient said “they don’t make you feel at all uncomfortable they are all sensitive to my feelings.”

People told us that they did not really have any concerns, but one patient told us that they felt that they needed to know more about their condition.

Most people told us that they had received information about the care and treatment options available to them although some didn’t feel that they had received enough information. People told us that they had not received information about the facilities available within the hospital or about what will happen when they leave the hospital. People told us that they understood the information that was given to them and that staff take time to ensure that you understand. One person said “the staff don’t really have much time to talk to you unless you need a lot of care.”

People told us that nobody had asked them to provide feedback about their care and treatment in hospital.

Other evidence

The trust declared that they were compliant with this outcome when they registered with CQC in April 2010. As part of this review the trust told us that they are compliant with this outcome. They also told us that their focus of ongoing work with this outcome is on improving the information which is available to patients including reviewing the bedside information folders following feedback from patients.

We reviewed the NHS inpatient survey from 2009. 95% of patients said that they were given enough privacy when they were being examined or treated. 82% of patients said that they were given enough privacy when discussing their condition or treatment. 91% of patients said that they were treated with dignity and respect during their stay in hospital. 73% of patients said that they were involved as much as they wanted to be in the decisions about their treatment. These were similar to the results expected for other NHS trusts.

In addition the trust provided evidence of patient surveys which they have carried out. The most recent was carried out in May 2010 and involved 93 patients over 33 wards. These results reflect that of the National NHS inpatient survey. The trust has identified actions to take as a result of this survey which included: ensuring that people are addressed by their preferred name and improving response times to patients requesting assistance.

There is a policy for the consent to examination and treatment in place within the trust. This provides staff with information and guidance about the different types of consent, how consent should be obtained from patients and what to do if a patient does not have capacity to give consent or if they refuse treatment. The trust also has a policy for resuscitation which includes clear information for
clinicians about the use of do not attempt resuscitation orders, their use and when and how to discuss and communicate with patients and their relatives about the use of these.

The trust provided us with examples of where they involve patients in assessing, planning and carrying out their care, treatment and support, e.g. nursing and medical admission assessment documentation. They also told us that they carry out focus groups with people who use the specialised services division services to find out what specific support they would like to have in place.

Although overall we observed staff behaving in a way that is respectful of people’s dignity we observed one patient who was exposed and three members of staff (not nurses) walked by him and did not cover him up.

We observed that curtains were drawn around patients whilst they were receiving personal care or treatment and that staff spoke to people at a low volume in order to protect people’s privacy. We observed that some of the curtains were poorly fitted, which may have an affect on their ability to protect people’s privacy. We also observed a calm atmosphere on the wards until lunchtime when on one ward staff not involved in the mealtime collected in the central nurses’ station and were very noisy.

We did not observe anyone being asked their views or preferences although patients did comment on the kindness of staff.

There is a movable locker by the side of each person’s bed for their belongings to be stored in. These were very secure. There was no hanging space for clothes within a wardrobe for patients by their bedside.

We observed that there are single sex bays on the wards that we visited and toilets and bathrooms are a short walk outside of the bays. The toilets and bathrooms that we saw were single sex and had signage to designate this. We found that there were no plugs in place in the patient bathroom sinks for people to use and this poses difficulties in promoting people’s independence.

We spoke with six members of staff, two of whom were senior staff. Staff told us that they ensure people are called by their correct name and ask people about their preferences, such as what they like to eat or what their washing preferences are. They told us that how they involve people in decisions about their care depends upon how ill they are and whether they are confused or lack capacity. Staff told us that if people lacked capacity they would involve their family and act in their best interests. Two members of staff that we spoke with had no knowledge of the Mental Capacity Act. Although senior staff had knowledge of how capacity assessments are carried out there was limited knowledge of this by other staff.

Staff told us that they ensure that people’s wishes and preferences are taken into account by engaging with them and talking with them and by ensuring that this is documented in the assessments and care plans. They also said that they would involve with relatives in people’s care.
The trust told us that staff have received equality and diversity training both as stand-alone training and incorporated within all people management training. The trust also told us that they have carried out staff “drop-in” training events on patients’ dignity and respect over the last year although the uptake of this training was low.

Staff told us that they had received training in privacy and dignity as part of their annual update mandatory training. Two members of staff told us that they had received “on the job training” as part of teaching sessions on the ward and one member of staff said that they were about to go on the “Essential Care Programme”.

Staff told us that they think that people’s privacy and dignity is maintained well on the ward. They all stated that curtains were closed around people, and that when they are closed staff ask before entering the curtained area. One member of staff mentioned that because there are no plugs for the sinks in the patient bathrooms it is difficult for people to maintain their independence by having a wash in the bathrooms. Staff said that overall they didn’t feel that they could improve on the privacy and dignity provided on the wards.

We reviewed six sets of case notes. We found variety in the level of recording in the case notes we reviewed. On one ward we found that there was very limited assessment of a person’s choices and preferences made on the admission documentation. In one case a person’s religion had not been recorded. The assessment was very functional and not person centred. On another ward we found that the standard of documentation and assessment of complex needs was person specific. On this ward we found on discussion with staff that they review the admission documentation with people when they are admitted to the ward from other areas of the hospital. We will be looking at record keeping at another review.

In the majority of cases we found that the records state what information has been provided to people about their clinical care. In one case we found that case notes were focused on medical needs and that there was no reference to nursing care needs such as, pressure areas, pain or hydration.

The trust told us that people should have an individual care plan which should be based on their individual needs, preferences and choices. These are developed from the admission documentation which should be person centred.

Most staff were clear that they would record and find details of a person’s diverse needs within their admission documentation. One member of staff said that they would use the handover sheets.

We observed that staff engage with people using services on a variable basis. Some engage with people more than others, but, overall staff do take time to listen to people.

We found that there were a large number of call bells which were out of reach, but that when rung they were audible and responded to swiftly. Where people expressed a need we observed people being supported in a timely manner. We observed one person being supported to the bathroom and when another requested a commode this was brought straight away.
During our visit we did not see an intentional round being undertaken by staff for those people who were identified as having a higher dependency. (Intentional rounds are focused round on people with complex needs and are in addition to planned rounds).

We found evidence that an assessment of people’s capacity to make decisions about their care had been made where necessary. In two cases there was no evidence that people had consented to share information with their family or next of kin. In one case we found that a DNAR (Do Not Attempt Resuscitation) order had been completed by the medical team but there was not evidence that this had been discussed with the person or their next of kin. We discussed this with a junior doctor and were told that this process tends to be medically led and that they do not tend to discuss this with the family.

Staff told us that they don’t always feel that they have enough time to give people the care they need. They told us that it depends upon the staffing levels, the dependence of the patients, and if you have a lot of admissions or discharges. Staff told us if they feel too rushed and can’t meet a person’s needs they would prioritise their work and ask for help as necessary. One member of staff told us “sometimes if you’re just that busy, you don’t think about it you just do it!”

The trust told us that they provide people who use services with written information leaflets in order that people are given the information that they need to make an informed choice. The trust told us that they have in excess of 1400 information leaflets which can be made available to patients in a number of formats including Braille or Audio information. We saw evidence of some of these leaflets during our visit to the hospital. The trust said that these information leaflets also include additional advice regarding healthy living for example, smoking cessation and nutrition for diabetics.

The trust has also told us that they have access to translation services, in order to ensure that people who do not speak or understand English can be clearly communicated with. This enabled patients who did not speak English to be able to understand their care, treatment and support including the risks and benefits and their rights to make decisions. These services include a bank of 68 translators which cover 33 languages and also a telephone translation service. The information provided to us by the trust indicates that the telephone translation service provider was changed in July 2010. However, the bedside information folder contains details of the previous provider. The trust has told us that it is updating the bedside information folders and we did not see anyone using translation services during our visit.

The trust provided us with examples of the information which is given to patients on the television screens which are at the patient bedsides. These screens were not in place on the wards that we visited.

Staff told us that they ensure that people understand the risks and benefits of their treatment and the options available to them, by talking to them, with their family
members there if necessary, by providing information leaflets from the trust document management system. If they need some support in this they would involve other members of staff such as doctors, or Dietitians. The nursing assistants that we spoke with said that they would get a qualified nurse or a doctor to explain to a person if they felt that person did not understand anything.

We observed that there was a ward leaflet available on the wards and there was a sign informing people of the protected mealtime on the door of each ward. We also observed people being given verbal information about the care that was being provided to them.

We observed limited encouragement being given to people to walk to washrooms for personal care. Most personal care was provided by the bedside when people could have mobilised. We observed one person being supported to walk to the toilet, one person being supported to walk to the bathroom and one person being supported in walking around the ward.

The trust told us that they employ a Patient Involvement Project Lead who is responsible for involving people in the service. The trust engages with Local Involvement Networks (LINks) and has been involved in numerous groups e.g. Bristol City Council Physical and Sensory Impairment Group; Bristol Physical Access Chain; Mental Health Operational Group; UBAX Somali Women’s Group and Bristol Multi-faith Forum. They trust has also provided us with examples of involvement groups which are in place within the hospital e.g. cardiac rehabilitation, Rheumatology, Maternity and Sexual Health.

Most staff said that they got feedback from people who use the service through thank-you cards and letters that are received. Four members of staff said that there were comment cards on the wards in addition to this. One member of staff said that although they had never thought of this [patients giving feedback], that if somebody made a complaint they would report it to a senior member of staff immediately.

Not all staff were sure how they would get feedback from people who were unable to give an informed view or who had special communication needs. Some staff (four out of six) said that they would engage speech and language therapists in order to communicate with people, and where appropriate use picture boards, get paper and pens for people to write things down on or if they required an interpreter this would be arranged. One member of staff used intentional rounding as an example of this.

Our judgement

We found that most people at University Hospitals Bristol Main Site were treated with dignity and respect. People told us that overall they were treated with dignity and respect. We found that the completion of admission assessment documentation was not always person centred and that information which would facilitate person centred care was not always completed. Although the trust told us that there are systems in place to gain feedback from people who use services, staff and patients were not clear how that would happen.
Overall we found that University Hospitals Bristol Main Site 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

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

Our findings

What people who use the service experienced and told

People told us that they were not talked to about what they like to eat and whether they needed support with their diet except for when making their menu choices in advance. People told us that sometimes, when they order two days in advance, they do not fancy the meal that they have ordered the day it arrives.

People told us that they are encouraged to eat more and are asked if they want more e.g. an additional pudding. The people we spoke to, who had missed a meal told us that they had been given some food when they returned to the ward but that this was toast or soup.

The people that we spoke with told us that they did not have any special needs when it comes to eating or drinking.

People told us that they do feel that they get enough food although sometimes the food which arrives is not what they remember ordering.

One person told us that they required help at mealtimes when they were first ill and that their nurse helped them, but that they no longer required help or encouragement.

The feedback we received from people who use the service regarding their description of mealtimes was variable. Some people said that they were not
reminded about hand washing although they did wash their hands before their meals and others said that it was difficult to wash their hands before eating. One comment was that sometimes the meals are warm and on time and other times they are late and cool.

**Other evidence**

The Trust declared non-compliant with this outcome when they registered with CQC in April 2010. Since then they have continued to declare non-compliance although the information that they provided us with as part of this review indicated that they hope to declare compliance at the end of May 2011. The trust reported at its board meeting in January 2011 that it was not performing to the standard aspired to with respect to this outcome and that it had action plans in place to rectify this.

We carried out a review of the trust in relation to this outcome in October 2010 and we asked the trust to make improvements relating to: observing protected mealtimes, ensuring that people receive the food that they have requested, ensuring that peoples’ food likes and dislikes are documented within the nutritional care plan and screening tools and that the information for staff regarding the ongoing needs of patients is than clearly being recorded in the person’s record rather than on the handover sheet.

The trust has provided the nutritional screening tools and care planning documentation as evidence. We also observed them in use on our visit. The trust has told us that they implemented new multidisciplinary nutritional documentation in autumn 2010. This paperwork contains core care plans for nutritional support and high risk patients have individual care plans which are devised by registered dietitians.

The trust has told us that it provides food and nutrition which is appropriate to the personal needs of each patient. This may not follow the concept of a “balanced diet” as their nutritional needs are different to those of healthy individuals in the community. This is determined following thorough nutritional assessment by a registered Dietitian. All dietitians within the trust must be registered with the Health Professionals Council. The main menu available is based on the principles of healthy eating. Staff who prepare the food are not involved in the development of menus as they are not qualified to do so – this is done by the dietetics team.

The trust provided a copy of the Management of Nutritional Care Policy, November 2010 as evidence. This contains information for staff about their roles and responsibilities with respect to food and nutrition, and also information about assessments, training required, oral nutritional support and hydration etc.

There is a standard operating procedure for the use and distribution of adaptive cutlery within the hospital which was approved and implemented in July 2010.

The trust has told us that advice regarding the correct position to feed patients is provided by Speech and Language Therapy (SALT) teams, physiotherapists and dietitians on an individual assessment basis.
The trust has told us that there is a protected mealtime policy within the trust. They also provided a copy of the Nutritional Steering Group Minutes for September 2010 as evidence. This identified that staff felt that the protected mealtimes were being “diluted over time”. The minutes also state that the new nutrition tools were being trialled at this time with some good practice but that this is not being replicated on a month on month basis.

The trust has told us that their April 2011 data showed that the protected mealtime policy is complied with on 25 out of 32 adult wards and six out of seven children’s wards.

The trust has told us that there are two nutrition nurse specialists within the trust (this covers adult areas there is no nutrition nurse specialist within the children’s hospital). They have also said that “if patients are correctly screened on admission they are identified in a timely fashion and referred to the appropriate healthcare professional”.

The trust provided a Food Policy service literature review as evidence. They have said that they are working towards this standard of best practice. The trust also provided a Food Safety Policy (June 2009) which provides staff preparing and serving food with the information and processes to follow in carrying out this role.

During our observations we did not see any patients being offered the chance to clean their hands before and after eating. We observed that there was a knife and fork sign in place above people’s beds to demonstrate that they are at risk of poor nutrition or dehydration. In some cases we found that this is misused and does not reflect the requirements which were recorded in people’s notes. There is also a system of using red cups, jugs and trays in place which is used to designate people who are at risk of poor nutrition or dehydration.

Most of the food appeared appetising. On one ward we found that the custard was lumpy and we found that the soft food option was mashed potatoes and gravy only. On another ward we found that there were options available for pureed and texturised foods available. We found that there was a variety of food available on the menu. However, there were no apparent choices for those requiring meals which reflect their cultural needs.

The trust provided their Nutrition Rolling Dashboard for February 2011 as evidence. This demonstrated that on 7 out of 32 wards people had not received their choice of food. The trust provided some examples of the patient menus that are in place within the trust. These identify the choice available to patients and include meals which cater for different cultural and religious needs and also texturised and pureed food.

Staff told us that they felt that mealtimes could be improved by a menu which changes more as people who are in hospital for a long time get bored with it. One member of staff said that they thought that the food did not taste nice. One member of staff told us that meal times are quite rushed although there are enough staff to
help to feed people if necessary. Another member of staff said that there was limited choice for people who have specific cultural requirements and they may get the same meal day after day. One member of staff said that the soft menu was not nice or appetising.

We observed that people were not disturbed during their mealtime. However, we found on one ward that there was a lot of noise in the central nurse’s station at lunchtime where staff congregated and that doors to the bays were not closed. On another ward there was a lot of noise on one bay when the multidisciplinary team meeting finished and staff left the meeting room situated off the bay.

We observed that people were supported when they required help with their nutritional needs. The support that was given was variable. We observed people being seated comfortably in preparation for their meal on both wards. Where people were supported in their feeding we found variety in the manner of the support. On one ward we observed people being supported by staff in a supportive and encouraging manner by engaging with the person on the same level (by sitting with them) and interacting with the person they were supporting throughout their meal. On another ward people were supported by staff that stood over them whilst they were being fed and there was limited interaction of staff with the people they were supporting. We observed one member of staff support a person in their eating and then stop half way through to go and check other people’s charts and urine output. Had this member of staff continued to support that person may have eaten more. However, the rest of the staff on this ward were very encouraging and ensured that people received help to eat their meal and were well supported in eating where necessary.

Staff told us that they would use the nutritional risk assessment to assess whether people are at risk of poor hydration and nutrition. Two members of staff told us that they would observe the people themselves to see if they show visible signs of being dehydrated as well.

Staff offered a variety of suggestions as to what action they would take if they thought there may be a risk of poor hydration or nutrition. They all said that they would refer the patient to the dietitian, one said that they would refer to the doctors, and one said that they would insert an naso-gastric tube and put up intravenous fluids. One member of staff said that they would check previous records, offer more fluids and communicate with other staff.

The trust has told us about the food and nutrition training which is happening within the trust: There has been a nutrition study day held at St Michael’s hospital which has been attended by over 50 staff (October 2010). All wards have received instruction from Nutrition and Dietetics Team on the use of the MUST tool. The trust has recently agreed to roll-out training provided by BAPEN (British Association of Parenteral and Enteral Nutrition) for all nurses who will complete this within a 3 month period from July 2011.
The trust has told us that it has food groups in place which meet at the Bristol Royal Infirmary, Bristol General Hospital, Bristol Haematology and Oncology Centre and St Michael's hospital and membership comprises of a variety of staff a including Matrons, Band 6 nurses, nursing assistants, housekeepers and hotel services staff.

All members of the trust Food groups have undertaken food, nutrition and hygiene training using an online training tool.

Three staff (50%) we spoke with said that they had received no specific training regarding nutrition. The other three members of staff told us that they had received a variety of training, including naso-gastric tube feeding, and training in the new nutrition assessment tool. Two members of staff said that they had received training sessions from the dietitians.

Four of the staff that we spoke with said that they were involved in mealtimes. They all were clear that there is a protected mealtime. Staff told us that they have a variety of involvement in mealtimes, from delivering the meal to supporting people eat. Staff told us that they encourage people to eat their food too. One member of staff told us that they stand over people when they feed them.

The trust declared rates of nutritional screening show that 94% of adult patients receive nutritional screening within 24 hours of admission (76% fully completed within 24 hours). The trust has told us that their catering ward rounds provide evidence that nutritional screening is not consistent across the trust.

They have told us that they have snack boxes available across the whole trust and that ward kitchens can provide additional snacks where people have missed a meal due to fasting or having missed mealtime for some reason. The trust has told us that they can meet the religious, social, cultural and nutritional needs of its patients. They have a comprehensive review of the food service and provision to metabolic patients underway currently. The trust has told us that it is now able to meet the nutritional needs of all its patients.

In most cases we found that people’s records contained a detailed nutritional assessment which had been completed by nursing staff with the main areas of risk identified and clear care plans in place to support people. In one case we found that although an assessment had been carried out there were no actual care plans in place with specific actions identified even though the person had been identified as being at high risk because they had difficulties swallowing. In another case the nutritional screening assessment had not been completed as the person had recently been admitted to the ward. This person had intravenous fluids in place but the fluid chart was poorly completed as was the food chart which was in place.

In two cases as there were not specific care plans in place we were unable to tell what help people required in eating and drinking. Where the care plans were in place people’s needs with eating and drinking were identified and the help required to support people in this was also identified.

Overall we found records of what people ate were maintained where they were required. However, in two cases we found that fluid and food charts had not been
completed well and that there were gaps in the record.

We found that people’s preferences with respect to food and drink were not recorded in the assessment in half of the cases we reviewed.

Overall we found in four of the six people’s records we reviewed that care plans were detailed and well defined. There was limited documentation to support the care needs of a person with complex needs who had been recently admitted... Another person’s record had an assessment which was not detailed and contained no care plan relating to nutrition and their food and fluid charts were poorly completed. We will be looking at record keeping at another review.

Staff that we spoke with were clear that they record and monitor people’s food and drink intake by recording it on their food and fluid charts. Staff told us that when people are transferred to the ward or are fasting they are able to ensure that people receive a meal as soon as possible after this because there are sandwiches available on the ward. Staff were also aware that they could get a hot meal for people from the Bistro. However, they told us that they don’t do this very often.

The trust has told us that it is in the process of developing catering bedside folders but that wards give information about times of meal service. However, the trust has said that practice is not consistent.

The trust has told us that patients are offered 2 snacks per day and that food is available which caters for Halal, Afro-Caribbean, Chinese, Sikh, vegetarian and vegan needs. The trust has told us that diet sheets, guidelines and protocols for individual special or therapeutic diets are available on the document management system to help patients make appropriate decisions about their nutritional health.

The trust has scored similarly to that expected in other NHS trusts in the Patient Environmental Action Teams (PEAT) scores in 2010 with respect of food (including menu choice, quantity and quality of food, temperature, presentation etc.) and nutritional screening. However, they proportion of wards operating a protected mealtime scored worse than expected in comparison with other NHS trusts.

Staff told us that they help people to complete their menu choices if they are unable to do so or if they have a specific diet or textured meal requirement.

Staff told us that they have adequate time to support people and their carers/relatives who require help with their nutritional care. One member of staff said “you have to find time, its important”. Staff told us that they think that the food delivery service from the catering department is good. They told us that the food comes at the right temperature, that the orders are mostly correct. Two members of staff told us that the deliveries are better during the week than at the weekends.

The trust has told us that they have procedures in place to ensure that patients who have fasted are monitored and reviewed appropriately. These include an Early Recovery After Surgery guideline which has been implemented. The trust has said that they cannot be confident that all patients are monitored for risk as the catering ward round would suggest. They have also said that they have not yet audited the ERAS guideline compliance.
Our judgement

We agree with the trust’s declaration of non-compliance with this outcome.

Although we saw some evidence that improvements in nutritional care have occurred this is not consistent across the trust and we saw evidence that patients do not always have completed nutritional assessments or care plans even if they have complex needs. People told us that they were not asked what they liked to eat or whether they needed support in eating. These are areas of concern which were raised in our previous review of this service in October 2010 and continue to be an issue.

Some staff do not feel that they have had specific training to meet patient's nutritional needs and we saw evidence that not all staff know how to support people when they need assistance with feeding.

We found that University Hospitals Bristol Main Site was not meeting this essential standard. Improvements were needed.
**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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
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<th>Outcome</th>
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<tbody>
<tr>
<td>Treatment of Disease, Disorder or Injury</td>
<td>14</td>
<td>5: Meeting nutritional needs</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
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<td>Surgical Procedures</td>
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<td>Diagnostic and screening procedures</td>
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**How the regulation is not being met:**

We agree with the trust’s declaration of non-compliance with this outcome.

Although we saw some evidence that improvements in nutritional care have occurred this is not consistent across the trust and we saw evidence that patients do not always have completed nutritional assessments or care plans even if they have complex needs. People told us that they were not asked what they liked to eat or whether they needed support in eating. These are areas of concern which were raised in our previous review of this service in October 2010 and continue to be an issue.

Some staff do not feel that they have had specific training to meet patient’s nutritional needs and we saw evidence that not all staff know how to support people when they need assistance with feeding.
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 28 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

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tr>
<td>Author</td>
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