Dignity and nutrition for older people

Review of compliance

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<th>Dorset County Hospital NHS Foundation Trust</th>
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<th><strong>Region:</strong></th>
<th>South West Region</th>
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<tr>
<td><strong>Location address:</strong></td>
<td>Dorset County Hospital, Williams Avenue, Dorchester, Dorset, DT1 2JY</td>
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<tr>
<td><strong>Type of service:</strong></td>
<td>Acute Services</td>
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<tr>
<td><strong>Publication date:</strong></td>
<td>June 2011</td>
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<td><strong>Overview of the service:</strong></td>
<td>Dorset County Hospital is the main site operated by Dorset County Hospital NHS Foundation Trust and links with satellite units in five community hospitals. It provides a full range of district general hospital services, including accident and emergency, to a population in west and north Dorset of around</td>
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<td>210,000. It has approximately 400 inpatient beds including older people wards and a stroke ward. Renal services are provided at the hospital and to a wider population throughout Dorset and South Somerset.</td>
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Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Dorset County 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 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.

We reviewed all the information we hold about this provider, carried out a visit on 27 April 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider’s records, and looked at records of people who use services.

What people told us
Patients told us were very satisfied with the care they received at Dorset County Hospital, describing it as very good or excellent most of the time. They said they had been treated with courtesy and respect and that their privacy and dignity had been well protected. They said they and their families were given clear information and explanation and had been involved in decisions about their care and rehabilitation. However, some patients told us that at times staff had been slow in responding to call bells.
Patients told us they felt their nutritional needs and dietary preferences were well met. They gave positive feedback about the quality, range and availability of food, including drinks and snacks. Patients who required assistance with eating or drinking were satisfied with the way staff supported them. However, some patients told us that the food is not always very hot and that sometimes mealtimes are a bit busy.

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

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

- Overall, we found that Dorset County 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**

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<td><strong>The provider is compliant</strong> with outcome 1: Respecting and involving people who use services</td>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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We spoke to ten patients and also observed the care provided to patients on two wards, a stroke ward and an orthopaedic ward. Prior to making the visit we looked at the feedback provided by patients on the NHS Choices website, the findings of the Patient Environment Action Team (PEAT) assessment and annual inpatient survey results.

Patients told us they were very satisfied with the care they received at Dorset County Hospital describing it as very good or excellent most of the time. They said they had been treated with courtesy and respect, and their privacy and dignity had been well protected. They said they and their families were given clear information and explanation and had been involved in decisions about their care and rehabilitation. However, some patients told us that at times staff had been slow in responding to call bells.
We observed that most, but not all, patients had their call bells placed within easy reach, for some this was rectified during our visit. On one ward staff had identified that a patient was unable to use a call bell so the door of his room was left open so he could call for assistance. Staff also went in to see him at regular intervals. Some patients said there were peaks and troughs in the demands made on staff and their capacity to respond. They told us that call bells were generally answered promptly or within five minutes. But we heard of some instances where patients waited much longer and we raised this with senior managers. This was also an issue identified in the annual inpatient surveys and senior managers told us that comfort rounds, aimed at anticipating patient needs, were being piloted on some wards.

The wards had interchangeable male or female bays and allocated toilets or bathrooms, so that men and women did not have to share accommodation. There were signs in place denoting male and female facilities. All the patients we spoke to told us they had never felt embarrassed or uncomfortable during their hospital admission. However, annual inpatient surveys indicate that some patients perceive they are sharing bathroom facilities with the opposite sex and the trust was reviewing how to address this.

Hospital staff were polite and friendly and they sensitively involved people whilst undertaking a range of care tasks. The atmosphere on both wards we visited was calm and welcoming. Personal care tasks were undertaken in private, with ‘no entry’ or ‘please ask before entry’ signs clipped to drawn bed curtains. There was good communication and teamwork between nursing, medical and therapy staff in assessing individual needs and in ensuring the comfort and safety of patients. We saw that staff generally had enough time to talk to patients and attend to their needs.

Patients told us they had been asked what they wanted to be called on their admission to hospital and that this was respected throughout their stay. We saw that patients had their names written over their beds. Hospital consultants and ward staff provided clear advice and information to people about their health needs, risks and the management of their condition. They listened to patients and explained what was happening. Staff supported patients to do as much as they could for themselves. Patients, and their relatives, were encouraged to ask questions and to be actively involved in decisions about their care.

None of the patients we spoke to had been asked for formal feedback on their care and treatment in hospital at that point. There were feedback and complaint information boards, leaflet racks and comment boxes on the wards. We were told that the stroke specialist nurse meets with patients one month after discharge to gain feedback on their experiences. A lunch club, run by volunteers twice a week, was open to both patients and relatives, and was being used as an opportunity for patients to provide feedback and suggestions.

Other evidence
The information we held about Dorset County Hospital prior to our visit showed that there was a very low risk of not meeting this standard. Patient surveys and (PEAT) assessment undertaken by the trust denoted strong performance by the Dorset County Hospital site in respecting and involving patients that use its services.

Staff interviewed had a good awareness of the standards of behaviour to ensure that patient privacy and dignity is maintained. They recognised individual patient needs and adapted their support accordingly. Staff had received training which covered promotion of privacy and dignity, the Mental Capacity Act and keeping people safe from harm. There were ward level resources and a link nurse for dignity and independence, who provided training sessions for staff on the ward. The matron and senior nurses monitored privacy and dignity through audit, observation and dissemination of feedback from relatives and patients. All the staff we spoke to were positive about good practice on the wards in maintaining patient privacy and dignity. Most staff felt they could do with more time to meet patient’s needs, or talk to patients, but they said they do as much as they can through team working and prioritising.

We reviewed seven patient records these contained a range of documents including the adult inpatient record and fractured neck of femur and acute stroke pathways. This stroke pathway was being used for some, but not all, patients on the stroke ward. Most records provided space for information about the individual’s faith, ethnicity, mental capacity, nominated contacts and home circumstances on admission to hospital, but not all were fully completed. One patient’s record contained best interest decisions and a deprivation of liberty assessment.

Nursing staff undertook bedside handovers when they changed shifts and individual patient needs and care were communicated. All wards used a lead nurse handover/ patient safety brief at shift handover to highlight patients with high risk needs, including wandering and falls. Although patient’s needs were being assessed and communicated this was not always documented in nursing records. This had been identified by the trust and an amended adult inpatient record was due to be implemented. The trust also undertakes regular audit of patient records as part of its ongoing commitment to raising standards. This audit, however, focuses on completion of assessments rather than the recording of patient or family involvement and views.

Patient records did not always reflect their choices or preferences, but staff confirmed that patients and their families were involved in discussions about planning their care. One record documented that the history was taken with the patient and his wife. We saw that care and treatment was discussed with patients at the ward round but records did not reflect these discussions. The records of multidisciplinary meetings evidenced team working focused on promoting patients’ recovery and monitoring any ongoing concerns. Staff on the stroke ward held goal setting interviews with individual patients, and their families. These were documented and reviewed as part of the weekly multi disciplinary meetings.

There was a welcome bedside folder at each bed space which contained basic
information about the hospital and facilities and included information on how to complain or make suggestions. The consultant physician showed us an information pack that he gave to patients and families when meeting with them. The specialist stroke nurse also holds information sessions for families and carers. Some leaflet racks were empty as they had been cleared as an infection prevention and control measure following a recent outbreak of noro virus. The trust was also was in process of reviewing all information to ensure it was up to date and 'fit for purpose'.

The Patient Advice and Liaison Service (PALS) officer told us that all the actions arising from complaints, as well as the learning from quarterly meetings of the hospital patients group, are collated. Any hot spots or themes are identified and communicated to matrons and cascaded to clinical teams. A matron told us of changes made in response to complaints for example, clearer information is provided to relatives so they know who they can talk to and how to get hold of them.

The trust had just undertaken a postal survey of 100 patients, with questions targeted at the themes identified from hospital wide complaints. The results were still being analysed. The trust was also planning a system of real time feedback and had started recruiting volunteers to undertake patient experience surveys on the wards. We found staff were positive about and open to learning from patient feedback provided in the process of care, through mini case conferences, or via staff meetings.

**Our judgement**

Patients at Dorset County Hospital are treated with dignity and respect. They, and their families and carers, are involved in making choices and decisions about their care and treatment. The trust has systems that support listening to and learning from the experience of patients, and these were being developed further.
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

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<td>There are minor concerns with outcome 5: Meeting nutritional needs</td>
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| Our findings |
What people who use the service experienced and told us

We spoke to ten patients and observed mealtimes on two wards, a stroke ward and an orthopaedic ward, including the care provided to patients. We also looked at the findings of the annual inpatient survey and results of the trust catering service satisfaction survey.

Patients told us they felt their nutritional needs and dietary preferences were well met. They gave positive feedback about the quality, range and availability of food. Patients who required assistance with eating or drinking were satisfied with the way staff supported them. Some patients told us that the food is not always very hot and that sometimes mealtimes are a bit busy.

On admission patients were provided with a pack of large wet wipes and the bedside folder asks patients to use the hand wipes provided prior to eating meals. The trust satisfaction survey indicates that over 70% of patients had been given a chance to freshen up before a meal. We saw some patients had washed hands after visiting the toilet but hand cleansing before and after eating was not part of the ward routine on the wards we visited. There was no evidence of staff prompting or helping patients to use the hand wipes before or after lunch.

The environment on the wards at mealtimes was organised and calm. The food appeared appetising, of suitable consistency and suitable portion sizes. Meals were delivered with the individual menu choice attached and a coloured and worded sticker noting any special diets. High protein diets were identified for those at medium or high nutritional risk. Pureed diets were provided in liaison with speech and language therapists and items were served in a tray with each pureed food separated. A soft menu was available from the ward menu choice. We were told that the hospital caters for religious and cultural diets for example Kosher and Halal foods, but there were very few requests for these.

On the stroke ward mealtimes were protected so that people were able to have their meals without interruption. Some other wards discouraged visiting at mealtimes and all baths, washes and therapy were stopped before lunch. These wards however, did not operate a fully protected mealtime. On the orthopaedic ward we observed that two patients had their meal interrupted between courses, and another was visited by external professional as their meal was being served. All three patients were eventually able to complete their meal. Staff on the orthopaedic ward thought that a fully protected mealtime would be of benefit to patients.

The trust catering service satisfaction survey indicated that all patients had help with eating if required. We observed that all those who required support with feeding were provided with assistance or prompting in a sensitive and unhurried way. Patients were sat up in bed, or in a chair, and were made comfortable. Their food was cut up as required to enable them to feed themselves. Independence was encouraged through the use of non slip mats and adapted cutlery. Meals were delivered with covers to keep the food warm and this was necessary as some patients waited 10 minutes before being assisted with feeding. The orthopaedic ward had a system of red lids on jugs for patients whose fluid intake was being monitored and blue dot stickers for patients identified as being nutritionally at risk.
All the patients said they had enough to eat and one had been offered second helpings. Most patients said the food was hot but a few commented that the food was not very hot. We saw staff checking that people were happy with their meal and encouraging people to eat. After the meal we saw patients being asked if they wanted a cup of tea or another hot drink. Drinking glasses and water jugs were placed within easy reach. Food supplements and thickened fluids were provided as required. We saw staff completing food and fluid charts before taking the meal trays away.

Patients were positive about choices on the menu. Nurses were able to ring the kitchen to get an alternative to the ward menu, or if the soft diet was not soft enough. Only one patient we spoke to had special dietary needs. Most patients told us that the food suited them and there was enough variety, one patient said their family also brings things they like. All patients were aware of the availability of snacks outside of mealtimes and some had seen others asking for toast in the evening.

Mealtimes were described as busy but orderly and patients felt they had assistance at the right time. One patient told us that they had chosen to take meals in the day room, when this option was offered. Two patients had missed a meal but said they had been given a choice of meal later on that day. High satisfaction with food quality and choice was reflected in the results of the trust catering service satisfaction survey, which also identified that there was enough menu choice to meet religious beliefs.

Other evidence
The information we held about Dorset County Hospital prior to our visit showed that there was a low risk that they were not meeting this standard. The Patient Environment Action Team (PEAT) overall assessment score for food had improved from good in 2010 to excellent in 2011. The annual inpatient survey indicated the hospital was performing better than average on quality and provision of food. However, we had undertaken a compliance review in December 2010 and identified the need for improvements actions to address poor recording, communication and inadequate review arrangements for a few patients at risk of dehydration. The trust has an action plan in place to address these issues.

We spoke to staff of different grades from a range of disciplines. Nurses and nursing assistants demonstrated a good understanding of the need to assess and identify people at risk of poor hydration and nutrition. They told us that monitoring the amounts that patients eat and drink works well on the wards through the use of food and fluid charts. They had good understanding of the steps to follow in the nutrition action plans and reported that referrals are made to the dietitians following instructions on the food chart. Some staff told us they had attended training on patient nutritional needs, for example a recent course on dysphagia awareness covered nutrition in depth. The stroke ward has a rolling programme of education and training provided by the specialist staff in relation to needs of individual patients. There was induction training for nursing assistants on nutrition and identifying
malnutrition, and nutrition training for newly qualified nurses and therapists, which also covered special diets and tube feeding.

Dietitians work as part of the multi disciplinary team but only see patients that are nutritionally at high risk. Dietitian assistants work on elderly care wards to check that action plans including food charts, high protein menus and supplements have been instigated when required. There is also a nutrition link nurse network; these nurses have a programme of study days and meetings, to support staff on the wards.

There is a designated hospital nutrition team, which includes a nutritional nurse specialist, and provides specialist review and advice regarding patients with tube or parenteral nutrition. We were told by the consultant physician that the number of staff in the speech and language therapy service had been increased following patient complaints about access. One therapist expressed concern that there was not enough speech and language therapy for patients to support them to start eating early after a stroke. Some nurses had been trained to undertake swallow assessments. We saw evidence of eating plans based on swallow and speech and language therapy assessment. These were in patient records and on notice boards above each bed in the stroke ward.

The hospital uses the Malnutrition Universal Screening Tool (MUST) to assess patient risk of malnutrition. The trust has a policy for all patients to be assessed within 24 hours of admission and at weekly intervals. The assessment tool includes specific care plans to be followed for people identified at low, medium or high risk. The plan for medium risk patients is instigated by nursing staff and includes a food chart, high protein meals, and snacks. After a week if the patient is losing weight and refusing nutritional supplements the plan directs staff to refer to the dietitian. All high risk patients follow the plan but are immediately referred to the dietitian, along with those on tube feeds. A dietitian told us that they provide half hour training sessions on nutrition screening and MUST action plans to nurses on the wards.

We reviewed seven patient records on two wards, including MUST, nutritional assessments, food and fluid charts. The assessments were not fully completed in all cases. In two records the MUST had not been completed, but a swallowing assessment had been undertaken for one and the intake for both patients was being monitored via the food chart and fluid chart. In another record the MUST risk score was not accurate, as it didn’t account for recent weight loss, but appropriate action had been taken to monitor food intake and involve the dietitian. We saw that food charts were well completed on both wards, and included the amount of food taken at each meal along with any nutritional supplements. However, fluid charts, particularly for oral fluids, were not accurately completed or totalled on a daily basis on the stroke ward. The lapses were highlighted to senior ward staff who acknowledged these were not always totalled, they told us that staff often relied on verbal feedback on fluid intake.

Matrons undertake quarterly audits of patient assessments, including the MUST score. This audit is done across all inpatient areas and we were told that improvements had been made. An annual audit on the completion of the adult inpatient record was done in October 2010. The results of this audit were poor and since then the trust audit team have undertaken monthly audits on the completion of the MUST. There had been some improvement over time, but in March 2011
results were poor for the stroke ward and across the hospital only 67% patients had a recorded MUST assessment and score.

To improve the use of the MUST, the stroke ward had identified Friday as a day for weighing and MUST review for all patients. We were also told of a new ward initiative, that if there was no record of weight and MUST for a patient then the weekly multi disciplinary meeting was halted until it was done. The weekly multi disciplinary team meeting record for each patient identified problems and progress as assessed and discussed by the ward multi-disciplinary team, including the dietitian.

All wards used a written lead nurse handover/ patient safety brief at nursing handover. This highlighted patients with high risk needs, including those patients who required help with feeding. Individual patient needs were being assessed and communicated but this was not always documented in nursing records.

The orthopaedic ward sister told us there was good communication between ward and theatres and usually no delays or excessive fasting for patients prior to surgery. The orthopaedic coordinator attends the early morning meeting which identifies when trauma patients will have surgery. There were sometimes delays for general surgical patients and the ward sister explained that patients were always prescribed intravenous fluids to cover this.

There was no detail of personal food preferences within the patient records but patients were provided with a daily menu with a wide range of choices. The hospital catering service had links with other specialist catering firms to provide a wider range of food to meet individual faith or cultural requirements. The stroke ward sister confirmed that volunteers had been interviewed and recruited to provide a restaurant style lunch club on the stroke ward with the aim of providing this choice for patients five days a week.

There is a lay representative who attends the trust nutrition steering group meeting which works to evidence and deliver improved outcomes and to promote a consistently high level of practice in this area.

Our judgement
Patient nutritional choices and needs are assessed and monitored and support with eating and drinking is provided where necessary. However, there is some incomplete and inaccurate documentation of nutritional assessment and fluid monitoring. On some wards patients may be interrupted whilst eating a meal.
**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.

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<td>5 - meeting nutritional needs</td>
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<td>Diagnostic and Screening Procedures</td>
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<td>Surgical Procedures</td>
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**Why we have concerns:**
There is some incomplete and inaccurate documentation of nutritional assessment and fluid monitoring. On some wards patients may be interrupted whilst eating a meal.

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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<td>Author</td>
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