Dignity and nutrition for older people

Review of compliance

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<th>Walsall Healthcare NHS Trust</th>
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<td>Manor Hospital</td>
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<th>Region:</th>
<th>West Midlands</th>
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<tr>
<td>Location address:</td>
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<td>Walsall</td>
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<td>WS2 9PS</td>
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<td>Type of service:</td>
<td>Acute services</td>
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<td>Publication date:</td>
<td>June 2011</td>
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Overview of the service:

Walsall Healthcare NHS Trust was formed on 01April 2011. Following the integration of Walsall Hospitals NHS Trust and NHS Walsall Community Health. The Manor hospital has 560 beds and provides the following services: Treatment of disease, disorder or injury, surgical procedures, diagnostic and screening
procedures, maternity and midwifery services, termination of pregnancies and services in slimming clinics.
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Walsall Manor Hospital needed to make improvements to both of the essential standards we reviewed. We have made suggestions for improvements.

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 13 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.

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. We visited two wards one of which provided care for people who had suffered a stroke. The other ward provided care for older people.

What people told us

Patients and their relatives we spoke to said they were treated with respect and their care and treatment needs were met. They said they had been involved in discussing and agreeing their care and were given clear information about treatment. Patients we spoke to on the whole said they enjoyed the food and felt their nutritional needs were being met. Everyone said someone came round with a menu to help them to choose what they wanted to eat. They said staff always checked to make sure they
have had enough to eat and that they have never missed a meal. Comments have included:

“I have never been in hospital before and found it reassuring when staff have explained what is happening next”.
“The staff were wonderful to mother and I feel less anxious about her mother now she was on this ward.”
“The food is very good on the whole. I left my meal today as I was not very hungry and staff asked if I was alright or if I wanted something else.”

What we found about the standards we reviewed and how well Manor 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 improvements were needed for this essential standard.

  Patients received care and treatment in a way that respected their privacy and dignity. Lapses in practice compromised this.

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

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

  Patient’s nutritional needs were being considered in a way which ensured that they get the nutrition they need. Patients may not always receive the fluids they need and this could impact on their health and wellbeing.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.
What we found
for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 1: 
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us

During our visit we spoke with nine patients and three of their relatives. They were mostly positive about their care and treatment whilst in the hospital. They said they were treated with respect and their care and treatment needs were met. Patients said they had never felt embarrassed or uncomfortable during their stay in hospital.

Patient’s and their relatives told us they had been involved in discussing and agreeing their care. One person said they had: “Never been in hospital before and found it reassuring when staff have explained what is happening next”. One person we spoke to said they felt a little anxious and felt that staff were a bit sharp when first admitted, but that they seemed better today. Some patients said they had been asked what they would like to be called, and that staff used the name of their choice. Others could not recall if they had been asked. A patient’s daughter visiting her mother told us that: “The staff were wonderful to mother and I feel less anxious about her now she was on this ward.”
One concern was raised with us before our visit regarding the withdrawal of food and fluid for an elderly patient without any consultation with relatives. We spoke to a relative of one person in the last phase of their life, who told us that they had seen the doctors most days and was very informed about the treatment given.

Of all the patients and relatives we spoke to no one said they had been asked to give feedback about their care.

Other evidence
The information we held about Walsall Healthcare Trust prior to the visit showed that there was a low risk that they were not meeting this standard.

We observed how patients were being supported and cared for and we spoke to 10 members of staff. On entering one of the wards and being shown around we saw a patient exposed whilst the nurses were giving care. The patient was visible by anyone in the corridor in front of the bay and there was a male talking to someone nearby. The nurse did try to draw the curtains but they did not close properly and the patient remained exposed and was not covered in a sheet or blanket. There appeared to be a curtain hook missing or damaged. There were other occasions where staff tried to close the curtains and were unsuccessful, because the curtain hooks were missing. During the day we saw other examples of staff closing the curtains before care was given to maintain patient’s dignity.

Staff on the wards were friendly and smiling. We observed patients being spoken to in a respectful and appropriate manner in most cases. There were a number of examples where staff were seen explaining things to patients before undertaking care and reassuring them. We saw staff asking people sensitively if they were in any pain and would they like any pain relief. There were occasions when some staff seemed over familiar with patients and did not use their name, but referred to the patient as “good girl.” Another member of staff called a patient darling, but the patient laughed, indicating they were not offended by this expression. We overheard a member of staff talking to someone about their medical needs, talking in a loud voice and the curtains were not closed. On a couple of occasions we saw staff talking across patients and not to them. We saw information about patients care needs on display over their beds and this would be visible to anyone visiting the ward. There was no indication as to whether or not patients had been consulted about how they felt about this. Whilst we have observed good practice overall in regards to patient’s privacy and dignity, our observations identified lapses in practice that compromises this aspect of their care.

Observations of care across both wards showed that call bells were within reach in most cases. Although there were instances where the call bells were not in reach. Patients on the whole felt they did not have to wait too long for bells to be answered.

The wards we visited were divided into single sex bays, with separate toilets bath and shower facilities. There were single rooms available with en-suite facilities. Each patient had a locker with lockable drawers for personal medication brought in from home.
Staff told us that there is lead nurse for older people and an older people’s champion. There is also a privacy and dignity group. Patients respect and involvement is mentioned both in induction and other training. A number of staff said they have study days where they discuss privacy and dignity. They also talked about the campaign held by the hospital in 2010, which focused on respect, privacy and dignity.

We looked at a small sample of patients care records. We saw that where people lacked capacity an assessment is done to ensure that decisions were made in their best interest. There were no apparent details of any choices that the patients were involved in within the records looked at. Patients preferred name was not written in the assessment record but there was a section for this on the board behind the bed of each patient. People did confirm to us that they were called by the name of their choice.

Information provided by the trust states that single sex room numbers have increased in the new build hospital. Processes are in place for gaining patients consent. Patient involvement is included in mandatory training for staff and in staff induction programme.

Senior staff spoken to said they involved patients in their needs assessment and care and treatment were tailored to meet their needs. Whilst planning care they ensure patients are asked about their activities of daily living and encourage them to do as much for themselves as possible. The aim is to ensure people are discharged independently. There were policies in place on privacy and dignity and Senior staff spoken to were clear that they would take formal action should they become aware that staff were not respecting patients privacy and dignity.

Where patients asked for something they were responded to and staff said they would get what they wanted. When they were with another patient they said they would be a moment but then they responded. Frail dependant patients were supported in washing, positioning, turning and supported with drinks and food where relevant.

Staff told us that patient’s needs and treatment options were discussed in the multidisciplinary meeting held. This is a team involving various professionals. Information is then passed to the patients during the ward round. They told us that if someone wanted to be discharged and they were not fit they would discuss the options and risks to them, but it is their choice and they could not stop them.

We were told that information about the hospital facilities is given in the hospital booklet. We found that a number of patients were not aware if there was a phone that they could use, some people had their own mobile phones. We saw complaints leaflets in a suggestion box on one of the wards we visited. Staff spoken to said they told people to complain to the nurse in charge and complaint information was in a pack at the bottom of each person’s bed. People were encouraged to raise concerns at ward level and information given about the patient’s advisory liaison service. We visited a ward where people who have had a stroke were cared for and information about their condition and treatment was included in a leaflet given to them.
We were told that people’s diverse needs were in the continuous assessment. Examination of the assessment showed that some issues relating to people’s diversity were included, we saw no reference to people’s cultural or religious needs in the assessments.

Information we have showed that the Trust has various methods that were used to gain patient’s views such as patient forums and surveys. We were told that there is an electronic system for doing surveys at ward level, which is currently being updated. Inpatient survey for September 2010 showed the overall picture for the Trust as a whole as: 90% of people said they had not shared mixed-sex room or bay after moving wards following admission. 70 % said they had not shared mixed-sex bathroom or shower areas. Patient experience tracker completed by the Trust in 2010 based on an average of 2,939 responses showed an overall score of 94% of people saying they were treated with respect by staff. The Trust has assessed its performance of involving people in their care as needing improvement. They have put in place an action plan to improve this.

**Our judgement**

Patients generally received care and treatment in a way that respected their privacy and dignity. Lapses in practice compromised this.

Overall we found that improvements were needed for 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

<table>
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<th>Our judgement</th>
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<th>Our findings</th>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>Patients we spoke to on the whole said they enjoyed the food and felt their nutritional needs were being met. Patients said no one had asked them about their likes and dislikes. Everyone said someone came round with a menu to help them to choose what they wanted to eat. One person said: &quot;I was not asked about what I would like to eat and whether I needed support, but menus were given daily.&quot; Most patients we spoke to said staff always checked to make sure they have had enough to eat. Only one patient said staff didn’t check with them. One patient said: &quot;I left my meal today as I was not very hungry and staff asked if I was alright or if I wanted something else.” Patients on one of the ward we visited was very much aware that snacks were available during the day should they require this, patients were not so aware of this on the other ward visited.</td>
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<th>Other evidence</th>
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<td>The information we held about the Trust before the visit showed no concerns about the Trust meeting this standard. A Patient Environment Action Team assessment, showed the hospital as performing similar to expected in most areas and much better than expected in others. This is a self assessment undertaken by the Trust, The hospital had a process in place for determining patient’s nutritional and hydration needs. The risks to patients are identified dependant on how they score in</td>
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the assessment. The information should then be transferred into their care plans, passed onto staff during handover and included on a white board behind the patient's bed. A review of a sample of records showed that in some cases there were discrepancies between the identified needs and the actual needs of the patients. This could lead to confusion if staff who do not know the patients well. One of the wards visited had nurses who were trained to assess patient's ability to swallow on admission. Staff spoken with confirmed that they had access to specialist support. These included dietitian, speech and language therapist, occupational therapist and dentist. Information we have showed that the Patient Environment Action Team assessment for 2011 indicated that 61-80% of the wards were using the nutritional screening policy.

Some staff told us that they had done bench marking training which included nutrition. The Trust told us that catering staff receive training from the dietitians, who also have an input into new nurses training regarding nutritional needs in hospital.

The hospital has protected meal times and relatives are encouraged to come in to support their relatives at meal times. Volunteers also offer support and the hospital said they are currently recruiting meal time mates. There is a red tray system in place which identifies patients who require support with eating and drinking. Staff said usually there is enough staff to support patients, although they said this depended on how many patients needed support. One staff said the wards have 34 patients and sometimes 33 patients needed help with eating and drinking. It was acknowledge that replacement staff were provided as far as possible.

Patients were able to have fortified drinks which were recommended by the dietitian to support their nutrition. Special diets were catered for and included in the menus. Staff told us that they can get culturally specific diets brought in quickly if needed.

During the visit we saw that no one was offered the opportunity to wash their hands before having their meal. When we asked patients they confirmed that they were not usually given the opportunity to do this. Lunch time observation on one of the wards showed that whilst the ward was busy, patients were not hurried and the atmosphere was conducive to eating. Patients were given assistance to eat their meals. Nurses sat down to feed patients, they made eye contact and encouraged them to eat. Patients who needed a culturally specific diet received one. The meals were seen to be of quite large portions, whilst some meals seemed appetising others was displayed in a not so appetising way. It must be stressed that none of the patients we spoke to complained about the meals. All patients had a beaker for their drinks, they were generally not always asked if they would prefer to use a cup. Although we did see a member of staff asking someone if they would prefer a cup after they had their lunch.

Food diaries were used for recording diet and fluid intake. Senior staff told us that staff were allocated to work in bays, with a senior nurse in charge of each bay, everyone has the responsibility to ensure that nutrition and fluids are taken. The ward sister or senior staff on duty monitors daily to make sure patients are eating and drinking. Staff told us if someone isn’t eating or drinking they made sure there
were no underlying problems.

Patients were not always given the assistance they needed to have a drink. We saw several instances where fluids were left that had not been taken. We also saw that some fluid charts were inaccurately completed to reflect the amount of fluids that had been taken. For example, we saw drinks left in a beaker and whilst this was in reach of the patient they made no attempt to drink it. The patient presented as being confused to place and time and was identified as needing a red tray. After half an hour the drink was still there and no one had approached the person or asked if they wanted the drink or offered assistance.

We saw one other patient who did not attempt to drink any of the three cups of tea they had during the visit. The records identified that 150mls of the morning tea and half of the lunchtime tea had been taken. These records were not accurate from what was observed. Staff did say that this patient was able to feed themselves although they seemed to be forgetting how to. Staff had supported this patient with their lunch. This could put patients at risk of dehydration and this was brought to the attention of the ward staff at the time of our visit. In one case the patient’s record showed that fluids were to be taken orally. In actual fact the patient required feeding via an alternative route.

Conflicting information on the records could have put this person at risk. The records we looked at showed the assessment process for identifying patient’s nutritional needs were disjointed in that the full information was not included in the records, but was often displayed on a board behind the patient’s bed. This shortfall in the records and processes will be fully looked into during future review of the Trust.

The wards visited had a “menu lady” who goes through the menu with patients to ask what they would like to eat. We observed this happening and she took her time and did not rush patients to make their choice. We saw a good selection of diets that included one lady who had a pureed ethnic meal. Some relatives will ask for a menu so they can complete it. The food is brought in frozen, there is a team of housekeeping staff who ensure they are reheated and served. Staff said the food is always hot and served well. Staff assured us that although sometimes the wrong meals were sent, this is rare. One staff told us that quality is not as good as it was. At matrons meetings the meals are tasted and feedback reported. Phone calls are done as follow up to patients stay in hospital, any concerns about the food are fed back to the caterers. The in patient survey for September 2010 showed a rating of 86 for the Trust overall in choice of foods. The national average for the top 20% of Trust is 89. The Patient Environment Action Team assessment for 2011 for food and hydration scored the Trust five out of five for most areas, with menu choice scoring four out of five. The Trust has identified a review of policy is needed in regards to patients who are fasting and there are plans in place to achieve this.

Our judgement
Patient’s nutritional needs were being considered in a way which ensured that they get the nutrition they needed. Patients may not always receive the fluids they need and this could impact on their health and wellbeing.
Overall we found that improvements were needed for this essential standard.
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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<th>Regulated activity</th>
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<td>Treatment of disease, disorder or injury</td>
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<td>1 Respecting and involving people who use services.</td>
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<tr>
<td>Surgical procedures</td>
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<td>Diagnostic and Screening Procedures</td>
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<tr>
<td>How the regulation is not being met:</td>
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<tr>
<td>Treatment of disease, disorder or injury</td>
<td>14</td>
<td>5 Meeting nutritional needs</td>
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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.
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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<th>Document purpose</th>
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<td>Author</td>
<td>Care Quality Commission</td>
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### Care Quality Commission

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| Postal address | Care Quality Commission  
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