# Dignity and nutrition for older people

## Review of compliance

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<th>Burton Hospitals NHS Foundation Trust</th>
<th>Queens Hospital</th>
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<td>Region:</td>
<td>West Midlands</td>
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<td>Location address:</td>
<td>Queens Hospital</td>
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<td>Type of service:</td>
<td>Acute service</td>
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<td>Publication date:</td>
<td>June 2011</td>
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<td>Overview of the service:</td>
<td>This provider is an acute trust and is licensed to offer services from two locations, Burton Hospital situated at Queens Hospital Burton-upon-Trent and Samuel Johnson Community Hospital in Litchfield.</td>
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The hospitals provide emergency services, medical and surgical investigations and a full range of diagnostic facilities and medical treatments for physical illness or condition, injury or disease.

Burton Hospitals NHS Foundation Trust is the principal provider of acute hospital services for the residents of Burton upon Trent and surrounding areas. The trust offers 420 beds and serves a population of some 360,000.

Burton Hospitals provide a wide range of general hospital services and acts as entry point to specialist tertiary centres and key clinical networks. The trust also provides a range of consultant outreach services into local community settings.
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Queens Hospital was meeting both of the essential standards of quality and safety we reviewed.

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

We reviewed all the information we held about this provider, carried out a visit, observed how people were being cared for, talked with people who use services, talked with staff, checked some of the provider’s records, and looked at care records for 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 carried out our unannounced visit on 6 April 2011 and visited two wards 42 and 44, which catered predominantly for older people. We observed the lunch time meal and looked in detail at the care records for five people. We spoke with nine patients and three visiting relatives. We spoke with a wide range of staff including volunteers and we also looked at a selection of other documentation.
What people told us:

Most people who used the service (patients) told us all the staff involved them in their care, treatment and support. They confirmed their privacy and dignity was respected. Most people told us that staff responded to their needs quickly and verified the staff were kind and explained what was happening to them.

Comments included:
“I am more than happy with the staff; their treatment is superior.”
“I am treated well. They do come and check on me regularly.”
“Normally they discuss things with me but when they take blood they just say; ‘I have come to take your blood’, I am not given a choice about having it done.”

We talked to people about meals and mealtimes and observed the lunch being served on two wards. People said they were offered a good choice at mealtimes. All but one person we spoke with were happy with the food, choice, portion size and how their food was presented.

Comments included:
“The food is really nice, loads of choice and not repetitious.”
“They have talked to me about diet and food, I am quite happy with the menu.”
“I only eat breakfast here my family bring my other meals in. The food is awful I can’t eat it. I get plenty of drinks though, including hot drinks.”

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

Outcome 5: Food and drink should meet people’s individual dietary needs
- Overall, we found that Queens Hospital was meeting this essential standard.
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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<td>The provider is compliant 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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During our visit to Burton Hospitals NHS Foundation Trust, Queens Hospital, we saw that in the majority of instances the staff involved patients and their relatives, (where appropriate) in decision making about their care. Some patients we spoke with commented they felt involved and could discuss their care because the staff were, “very friendly, kind and caring.” We overheard care staff and nursing staff giving helpful descriptions and explanations to patients about the support they were offering. On all occasions we noted curtains were drawn to ensure that privacy and dignity was maintained.

All but one of the patients we spoke with were satisfied that the treatment options available to them, and they said these had been adequately explained. Some people we spoke with had communication difficulties and could not remember clearly what they had been told. It was evident on speaking with the staff that everyone was knowledgeable about the patients on the ward and understood their individual needs. The staff could clearly identify people and were able to provide
informative answers when we asked for specific information about patients. The staff confirmed they had a handover on every shift and felt this was valuable. This was where important information was passed on from one shift to another and shared with the staff to ensure continuity of care.

We consider some improvements could be made regarding consent to care and treatment. This is because we observed and were told the following:

“Normally they discuss things with me but when they take blood they just say; ‘I have come to take your blood’, I am not given a choice about having it done.”

We spoke with an occupational therapist who told us:

“An introduction to each patient is offered daily prior to gain consent for interventions. It is essential to ascertain the patient wants to engage at that time, otherwise we will come back later.”

We observed patients spending time with the occupational therapist, but they did not receive any further input during our visit by any of the ward staff. One person was waiting for a walk with their walking frame. They were promised this three times during the morning and were still waiting at lunchtime. The patient told us, “this was a problem on the ward” and, “we do not get the opportunity to walk often enough.” One person said, “I could do with this three or four times a day and I get it once if I am lucky.”

The ward staff told us most complaints from relatives and patients were about the lack of therapy services. They said; “people can’t believe we operate a five day service when patients require interventions seven days a week. If a patient is admitted on a Friday, they won’t get seen till Monday.”

The staff were observed treating patients with respect at all times. Patient’s privacy and dignity was maintained. Toilets and bathrooms were within easy reach. All patients were accommodated in single sex bays or wards when we visited. Patients we spoke with felt the staff were respectful and told us that staff called them by their preferred name, which was written over their bed, as was other significant information.

People told us:
"They always draw the curtains they explain things well if I don’t understand."

There were good interactions noted, the staff were professional, kind and caring towards patients. All patients on the wards were sitting out of bed, in their own clothes or pyjamas. It was evident they had good personal care delivered because everyone looked well cared for, and the bed space was clean and tidy.

We spoke with patients about their call bells, (all were seen to be close at hand) and if they considered they were treated with dignity, here are some of their comments:

“I do ring the bell at night and it is not long until they come.”

“They cover me with a towel and help where help is needed.”
One of the staff told us they were continually trying to improve practice. An example they gave was that they now always close the curtains when patients were using equipment such as a frame or rotunda. This was introduced in case the patients felt people were watching them, which could make the person feel under pressure or uncomfortable.

Other evidence

Information we hold about the provider tells us there are no concerns raised in relation to dignity, by the outcome risk estimates. The patient environment action team (PEAT) scores identified in the national patient safety agency (NPSA) from the latest survey, January-March 2010 records ‘excellent’ in this outcome. Besides obtaining views of people during our visit we also looked at NHS Choices which is a website where people can post comments about the service they have experienced. This was last updated on June 18 2010. It told us 68% of people (11 out of 16) would recommend the hospital to a friend, people had posted comments which included: “The patience, professionalism and kindness I was shown was great. I was kept well informed of what was happening and what was going to happen. To sum all the staff up that day in one word I would use ‘excellent’.”

We spoke with senior ward staff who discussed the national dignity agenda, the staff were very aware of its content and it was evident they promote this within their areas. Matron, sister and the nursing assistant attended the national dignity conference recently. The trust had adopted a positive approach to the involvement of people and their families in the delivery and shaping of care.

Both matron and the head nurse were new in post. They told us actions from complaints were discussed at monthly meeting whereby all staff were encouraged to attend to ensure learning takes place. ‘Afternoon tea’ with matron was offered to encourage interaction and communication with staff, patients and relatives. Patient Advice and Liaison Services (PALS) attended this too. It was evident patient information and feedback was considered as “rich information” and clearly used to review and improve care and services.

Our judgement

People who use the service were treated in a way that promoted individuals privacy and dignity. People received clear assessments and suitable information to help inform their choices.
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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Our findings

What people who use the service experienced and told us

We observed lunch being provided on two wards, people were positive about the choice of meals offered and told us the food was always hot. They told us that plenty of drinks were made available and that the staff provided them with jugs of fresh water and juice, this was evidenced throughout our visit. The menu was available on the menu board on one ward but not on the other, everyone chose what they wished for at meal time. Choices on the day we visited included pasta, roast pork, fish, mince, a large vegetable selection and pureed meals.

One person told us; “when I first came in and was able to talk the nurse sat down and asked me questions, and spoke to my son. She wrote everything down. I have a diabetic diet and they just help me to cut up my food, which is all the help I need.”

Other comments included:
- “I’m always asked what drink I want and if I want milk and sugar.
- “I was given cold porridge once but they soon changed it when I complained.”
- “The food is really nice, loads of choice and not repetitious.”
- “They come and ask if I want a top-up or seconds.”
- “They have talked to me about diet and food, I am quite happy with the menu.”
- “There is always a jug of fresh water on my table.”
The staff were heard asking patients if they would prefer water or juice to drink and we regularly saw drinks being encouraged and jugs topped up. During the morning drinks trolley everybody was asked what they would like, and given various options. People were asked whether they would like their drink in a beaker or a cup and saucer, both sugar and sweeteners were available, as were biscuits.

We observed that not everyone was offered the opportunity to wash their hands prior to their meal being served, or after eating. One person commented with regard to hand washing; “this never happens, today was the first time.”

The expert by experience spoke with five people; nobody was offered hand cleaning facilities.

Other evidence

We saw people were appropriately supported to ensure they were sitting comfortably in preparation of their meal, which were served individually on trays from the heated trolley. The food smelt nice and appeared appetising. All staff responsible for serving the food were wearing personal protective clothing. We were told by staff that people who may be at risk were identified on each handover. The registered nurse directed staff to ensure those who needed assistance received it. There was no red tray system in place; this is a system used to identify people who require support or may require a specialist diet for example. The matron on one ward said a red tray liner was in use to identify those at risk although these were not seen. However, we saw the type of diet needed was clearly identified above each patient’s bed.

There were clear demonstrations of protected meal times; this means that no interruptions were allowed during this time, for example doctors visits or interventions. We also observed that the patients relatives were supported to choose meals and be involved with the meal delivery if they so chose. All patients who required assistance were provided with support. All the staff observed supporting patients with their meals were patient in the task, sat close by and offered reassurance. We did note that one staff member sat on the patient’s bed to do this; this is not good practice. We observed drinks were within reach of patients at all times. The meal delivery was calm and efficient but the nursing station on one ward was noisy. Sisters on both wards verified there were sufficient staff on duty.

We were told by a number of staff that if someone missed a meal, snacks were available such as jacket potato, biscuits, sandwiches, and soup. The menu offered a cooked breakfast and cereal, toast, etc. There was a hot meal at lunch time and the evening meal was usually soup, salads, sandwiches and fruit.

The staff told us they identified patients who are at risk of poor hydration and nutrition via the Malnutrition Universal Screening Tool (MUST) assessment. This is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
Patients were assessed on admission and then weekly. Staff told us people were weighed every Saturday and Sunday as a matter of routine. They confirmed that if a patient was identified at risk, or a concern was raised, food and fluid charts were completed and a referral was made to the dietitian. They also said that at the end of a shift the registered nurse completes documentation, and this would include reviewing food and fluid charts.

We found evidence of nutritional assessments and nutritional care planning had taken place for patients. A nutritional risk assessment was completed within 24 hours of admission, supported by information from patients on their normal dietary intake and for any conditions which may impact on their nutritional intakes, such as diabetes.

Where the risk assessment identified a patient was at risk of malnutrition or dehydration, a plan of care was put in place. This included close observation of fluid and food intake, involvement of the dietetic team or artificial feeding. Patients who had swallowing difficulty could be referred to the speech and language team (SALT) for an assessment. Referrals made, and any care plan from these were well documented in the main care plan.

We found that care plans were developed in line with assessments completed and included whether the patient required assistance with eating and drinking. Fluid balance charts were used for patients whose hydration intake was to be recorded. We saw nutritional input charts specifically for patients who had little appetite and needed encouragement to eat. During our visit we looked at records relating to fluid intake for people who are unable to give themselves drinks or who were otherwise at risk of becoming dehydrated. All fluid intake charts we looked at had been completed and updated as required.

Overall we found good documentation on the two wards we visited, there were detailed care planning systems in place including risk assessments and appropriate preventive measures to ensure the safety of the individual. The overall PEAT score for food published by the NPSA from early 2010 rated Queen’s Hospital as ‘good’.

The Staffordshire Local Involvement Network (LINk) had recently visited the Queens Hospital. Their report recorded; ‘the meal trolley arrived promptly and there was a choice of at least three main courses. All the food looked freshly prepared and hot. Portions were generous.’

**Our judgement**

People were provided with a good choice of nutritious food and drinks, and offered enough time to eat without interruption. Nutritional assessments and appropriate support were offered where necessary, this ensured people received adequate nutrition and enjoyed a healthy diet.
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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<th>Document purpose</th>
<th>Review of compliance report</th>
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<td>Author</td>
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## Care Quality Commission

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