Dignity and nutrition for older people

Review of compliance

North West London Hospitals NHS Trust
Northwick Park Hospital

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<th>Region:</th>
<th>London</th>
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<tr>
<td>Location address:</td>
<td>Watford Road, Harrow, Middlesex HA1 3UJ</td>
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<tr>
<td>Type of service:</td>
<td>Acute Services</td>
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<td>Publication date:</td>
<td>July 2011</td>
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Overview of the service:

Northwick Park Hospital is a major acute hospital in north west London. The Trust provides acute hospital services to more than half a million people living in the London Boroughs of Brent and Harrow, as well as patients from all over the country. The hospital has 535 beds, of which 64 are maternity beds. As well as general medical and surgical services, the hospital provides a 'hyper acute' stroke unit, a maternity department, and a children's department. The accident and emergency department has an urgent care centre attached.
We found that Northwick Park Hospital was meeting both of the essential standards of quality and safety we reviewed but, to maintain this; we suggested that some improvements were made.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

This review was part of a targeted inspection programme in acute NHS hospitals to assess how well older people are treated during their hospital stay. In particular, we focused on whether they were treated with dignity and respect and whether their nutritional needs were met.

How we carried out this review

We reviewed all the information we held about this provider, carried out a visit on 17 March 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. We visited two wards in the hospital, Fletcher Ward which specialises in the care of older people and Evelyn Ward, a surgical ward, specifically a trauma and orthopaedic ward. We spoke to seven patients or their relatives and seven members of staff on the two wards.

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

Patients that we spoke to were happy with the care they were receiving and said that they had been treated with dignity and respect by staff. On Fletcher Ward staff were described as ‘hot on closing curtains’ when giving personal care. There were mixed views about the quality of food provided, although the majority of people said it was acceptable and there was ‘plenty of it’. Some patients told us they were helped by staff with their meals and that snacks and drinks were readily available.

What we found about the standards we reviewed and how well Northwick Park 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 Northwick Park Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

- Overall, we found that Northwick Park 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.

Where we have concerns, we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

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

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us

We spoke to older patients and relatives on both wards we visited about the way they had been involved in their care and asked them how they had been treated. Everyone said staff had treated them with respect and dignity. Some comments we received included: ‘they always pull the curtains around (when giving care)’ and ‘I haven’t felt embarrassed (when receiving personal care)’. On Fletcher Ward a relative told us ‘they are very hot on closing the curtains and using the pegs to indicate privacy is needed’.

Patients also told us that staff had explained their treatment to them and offered them choices where possible. For example, one patient told us ‘I have been given a choice. They explained two ways of doing things and accepted what I wanted.’ However, one relative of an elderly patient who did not speak English said that doctors only made their rounds in the morning, when visiting was not allowed, so the family could not speak to the doctor directly. The relative told us that she always looked for the ward sister who ‘explains everything’. She had not been offered the
opportunity to speak to a doctor at another time. The same relative said that a physiotherapist had used her to interpret for the patient during a treatment session. This occurred because she happened to be present rather than it being prearranged. On the day of our visit staff asked this relative to write down key words in the language spoken by the patient in order to facilitate communication. However, the patient had been on the ward for more than a week before this was done.

Other evidence
We observed staff interacting with patients on both wards. Except for one occasion when a nurse was quite dismissive of a patient’s concerns, the majority of staff were caring and compassionate. Patients were encouraged and helped go to the bathroom and toilet where possible rather than receive personal care at the bedside. This encouraged independence and protected privacy.

Staff pulled curtains around beds before care was given to patients. On Fletcher Ward curtains were secured with pegs and a notice attached reminding others to ‘knock’ before entering. On Evelyn Ward, however, curtains were ill-fitting and not closed properly on numerous occasions meaning privacy was not always respected.

Nurses were always present in the patient bays and generally responded quickly to patient requests without them having to press the call bell.

On Fletcher Ward we observed one patient where bed rails were in use. A review of their records showed that a falls avoidance tool had been completed but there was no evidence that the patient had either consented to the use of bedrails or that a capacity assessment had taken place if the patient lacked capacity. There was also no record of involvement of the family in this decision.

Staff told us that they involved patients by communicating with them directly and liaising with relatives if the patient had dementia or communication difficulties. They said they used assessment documentation and care plans to record this. However, there was little evidence of any information being provided to patients or of family involvement in the records. We also found little evidence of assessment of patients’ capacity to give informed consent. Some of these issues are covered under outcomes and will be followed up in a later review of the hospital.

Little or no written information was provided to patients on Evelyn Ward in relation to their care and treatment or stay on the ward. The ward manager said that patients undergoing elective surgery were informed about the procedure at their pre-admission assessment. However, no information was provided to trauma patients. A senior manager told us she relied on staff to explain the necessary information to patients but she did not know what information was provided.

On Fletcher Ward, however, a simple but comprehensive information leaflet had been prepared and was given to patients and their relatives on admission. This included information on who to contact, visiting times, how to make a complaint and how to contact the Patient Advice and Liaison Service.

The Trust provided us with the results of a patient experience survey from October 2010. It showed 95% of patients said they were treated with dignity and respect on their ward and 84% of patients reported they were as involved as they wanted to be in decisions about their care and treatment.

Policies were in place for staff in relation to respecting the dignity and privacy of patients. The Trust undertook audits of privacy and dignity on the wards March 2011 and we saw that on one ward, where concerns had been identified, an action plan aimed at improving care had been put in place. For another ward although minor
concerns had been identified there was no record of what was being done to address these.

Our judgement
Generally patients were treated with consideration and respect and independence was encouraged. Attempts were made to protect patient privacy but these were not always effective. Written information was available but not always provided to patients and relatives on all wards. Some patients who had capacity were involved in decision-making in respect of care but for those patients who had dementia or difficulty in communicating, evidence of involvement was limited. This inability to provide adequate information for patients and families could put them at risk of their views being unknown and human rights unrecognised in respect of care and treatment.
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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<th>Our judgement</th>
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<td>There are minor concerns</td>
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<th>Our findings</th>
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<td>What people who use the service experienced and told us</td>
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<tr>
<td>We spoke to several patients and relatives on both wards and asked what they thought about the food provided to them in hospital. Most people told us they were happy with food although there were mixed views. One patient said ‘there is plenty to eat and drink’ and others said it was hot enough. One patient told us it was served promptly: ‘they don’t leave it sitting there; they bring it when you are ready’. A carer, however, reported that the meal provided to her relative the day before had been undercooked.</td>
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<td>Patients told us they were offered a choice and menus took account of cultural needs and preferences. One carer, however, thought that the food choice was quite poor for her relative who was receiving a soft diet. Patients said they usually received the food that they had ordered and one person said ‘once they forgot my order but they still managed to get something I liked’. They also described coming back to the ward from the operating theatre and although they had missed lunch time a meal was provided for them.</td>
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<td>Patients told us that drinks and snacks were made available when they wanted them. Some patients reported being assisted by staff if they had any difficulty at meal times, for example, one patient said she received help with opening yoghurts.</td>
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Other evidence

We observed the lunchtime meal take place on both wards. The overall environment was very calm and peaceful during the lunch period. There were no interruptions during the serving of meals on Evelyn Ward. On Fletcher Ward, however, a consultant was visiting a patient whilst their lunch was sitting on a table going cold. Patients on Fletcher Ward were helped to clean and dry their hands before lunch. We did not see this happening on Evelyn Ward. Patients were positioned well and food and drink placed within easy reach. Patients with ‘red trays’ were assisted to eat by staff whilst others were prompted and helped to arrange their tray. Patients with other coloured trays also received one to one help to eat and drink. Staff offered support as soon as the food arrived. Staff opened packets of sandwiches onto the plate for those unable to open them themselves, although this happened inconsistently on Evelyn Ward. We observed one patient who had not originally chosen soup from the menu was able to change their mind and have soup when lunch arrived. Overall the soup looked appetising and the sandwiches looked fresh.

Staff told us that Malnutrition Universal Screening Tool (MUST) forms were completed on admission to identify those at risk of malnutrition and food and fluid charts put in place where concerns were identified. The senior manager on Evelyn Ward told us that no audits or reviews of nutritional assessment and care had been carried out. The ward manager on Fletcher Ward told us that weekly audits of MUST forms were conducted on the ward to ensure all patients were assessed.

When we reviewed patient records on both wards we found inconsistent recording of patients’ current nutritional needs and status. MUST assessments had sometimes not been completed at the time of admission. For one patient the MUST score had not been reviewed weekly and only completed twice since admission two months before. There was also inconsistent recording of food and fluid intake. Where food charts were in place to measure patient intake there was frequently no indication of the amounts eaten and there were gaps suggesting the patient had not eaten anything at a number of meals. This was the case for one patient where weight loss had occurred since admission and the MUST score indicated the patient was ‘at risk’. It was, therefore, not always demonstrated that patient nutritional and hydration needs were assessed, reviewed and monitored in the plan of care.

One elderly patient on Evelyn Ward, who was suffering from dementia, went without food and oral fluids from midnight on three consecutive days until his operation was cancelled each day. On the day of our visit he was provided with a cup of tea when the nurse became aware the operation had been cancelled at three o’clock. The patient had been nil by mouth for fifteen hours until then although he had received intravenous fluids. This put the patient at risk of inadequate nutrition as well as unnecessary discomfort.

Menu choices were available to meet a range of diverse cultural and other needs including vegetarian, Halal, Kosher and puree meals.

The Trust told us that they were about to re-launch protected meal times on the wards and guidance had been ratified by the Trust Board. It was also stated that an audit of the use of MUST forms will be added to the annual audit programme.

Some staff said they received annual nutrition update training and dietitians were available to give dietary advice. Fletcher Ward conducted their own in-house nutritional training and staff had been involved in food tasting.

A survey of patient and staff views of hospital catering services in August 2010 reported that patients wanted more choice and food was frequently not served at the
correct temperature. Patients felt they needed to eat more in the evening owing to the long gap until breakfast, sometimes as long as 15 hours. The Trust subsequently changed the serving of the main meal of the day to the evening, although the gap between the evening and breakfast meals appeared to remain the same. This showed the Trust had listened and responded to patient feedback.

Our judgement
The Trust had processes in place to identify and monitor people who were at risk of poor nutrition and hydration, but these were not being implemented consistently. Although we saw that patients were given assistance with feeding where required, protected meal times were not fully implemented on one ward and patient’s meals were sometimes interrupted. Nutrition assessments were not always available or not completed in full. Where patients were considered ‘at risk’ of poor nutrition subsequent food and fluid monitoring was often inconsistent or inaccurate. As a result not all patients were being protected from the risks inadequate nutrition and dehydration.
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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<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<td>Treatment of disease, disorder or injury; surgical procedures; diagnostic and screening procedures; assessment or medical treatment of persons detained under the 1983 Act</td>
<td>17</td>
<td>Outcome 1: respecting and involving people who use services</td>
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Why we have concerns:
Generally patients were treated with consideration and respect and independence was encouraged. Attempts were made to protect patient privacy but these were not always effective. Written information was available but not always provided to patients and relatives on all wards. Some patients who had capacity were involved in decision-making in respect of care but for those patients who had dementia or difficulty in communicating, evidence of involvement was limited. This inability to provide adequate information for patients and families could put them at risk of their views being unknown and human rights unrecognised in respect of care and treatment.
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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>
<td>Care Quality Commission</td>
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