Dignity and nutrition for older people

Review of compliance

United Lincolnshire Hospitals NHS Trust **Grantham and District Hospital**	
Region:	East Midlands
Location address:	Grantham and District Hospital 101 Manthorpe Road Grantham Lincolnshire NG31 8DG
Type of service:	Acute Services
Publication date:	June 2011
Overview of the service:	Grantham and District Hospital provides acute services to Grantham and the local area. It provides consultant medical and some surgical specialties. It also has a midwifery led maternity unit and provides 24-hour accident and emergency services.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Grantham and District 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

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 23 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.

What people told us

In March 2011, we visited two medical wards at the hospital and spoke with many patients. During our time on the wards we observed interactions between staff and patients and saw that staff were behaving in a way that was respectful to people. All patients told us that they had been treated with dignity and respect and many patients were very complimentary about the care they had received. For example, one person said, “the staff are so caring, they look after everyone extremely well in here.”

Patients told us that their needs were always met by the staff. Without exception all of the patients and relatives that we talked to were very happy with their care. For example, one patient said “you can’t fault anything.” Another said “it’s like a holiday home here, we are treated so well.” Patients also said that they felt the staff listened to them. We observed all patients had access to their call bell and these were not left ringing.

Patients told us that meal times were very clam and the food was always warm enough and they always got the help they needed to eat their meal. The majority of the patients said they enjoyed the food. We saw staff encouraging people to eat their meal but were respectful of patient’s wishes if they did not want to eat. We observed one patient not wanting to eat and heard the staff offer them of a pudding instead as they knew they preferred puddings.

Throughout the visits to the wards we observed patients had access to drinks and they were placed within reach. Hot drinks were served regularly and we heard one patient asking for a cup of tea outside of the drinks round and saw that the healthcare support worker went to fetch them one.

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

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

Overall, we found that Grantham and District 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

Our judgement

The provider is compliant

with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Between May 2010 and January 2011 there were three positive and three negative comments made on the NHS Choices website relating to peoples experiences of being treated with respect. These comments were not specific to Grantham and District Hospital and could have related to other hospitals within the trust. The national in patient survey published in 2010 showed that the trust scored about the same as other similar trusts but again, the results of this survey are trust wide and are not broken down by hospital location.

In March 2011, we visited two medical wards at the hospital and spoke with many patients. During our time on the wards we observed interactions between staff and patients and saw that staff were behaving in a way that was respectful to people. For example, we saw a nurse talking with a patient who was confused.

We observed the bed area curtains were in working order and staff used “do not

enter" signs on the curtains to prevent people coming into the bed area. A doctor told us "we always close the curtains and use the do not enter signs to maintain peoples privacy." Staff told us that they always respect these signs and ask before entering the bed area. We observed staff consistently doing this on both of the wards we visited. Patients also told us that staff don't just enter the curtains, they ask first.

We observed staff asking patients what they wanted to do and giving them choices. For example, one person did not want help to have a shave so the nurse said she would see if he wanted to do it later. We heard the ward housekeeping assistant ask patients what they wanted to drink and observed her chatting with patients as she gave out the drinks. We observed that staff had good relationships with patients and did take time to talk with people as much as they could. There was good communication between staff and patients, for example, we observed a nurse who crouched down to talk to a patient who was sitting in a chair. This meant that the nurse could make eye contact. We also observed two physiotherapists helping a patient to walk, as they were doing this they talked with the patient and treated them with respect. We also heard staff introducing themselves and on one occasion, we heard an occupational therapist ask a patient what they would like to be called.

Staff told us that they always tried to make sure that patients understood what was happening to them. The doctor for example, told us that they would spend time with the patient to talk about their treatment plan and make sure they understood. Nursing and therapy staff told us they would always explain everything to the patient in a way that they could understand. A ward sister told us that risks and benefits of care are discussed with patients and carers or relatives. A patient confirmed this and told us the nurses had explained about the risks of getting a blood clot and how they could help prevent them. Another patient said, "they have told me what is happening to me and explained everything, they are very helpful." One relative of a patient said, "they (the nurses) keep us fully informed, I think the communication here is excellent."

At the time of our visit, both wards were full but the wards were quiet and staff were not hurried. On one occasion we saw a patient who had moved their bed sheets, leaving some of their legs exposed. A nurse spotted this and quickly went to the patient to ensure he was covered. We observed all of the patients were being nursed in single sex bays or in single side rooms. The toilet facilities were single sex, but the main assisted bathroom was for both male and females. The staff told us that generally patients would only use the assisted bath with a nurse. The doors to all of the toilets and shower/bathrooms had signs that could be changed to male or female as required.

Staff told us that the hospital chaplain visits the ward every day and if a patient wanted to see someone from another faith the chaplain would help organise this. Patients told us that they were asked about their religious and cultural needs when they were admitted to the hospital.

Patients told us that their needs were always met by the staff. Without exception all of the patients and relatives that we talked to were very happy with their care. For example, one patient said "you can't fault anything." Another said "it's like a holiday

home here, we are treated so well." Patients also said that they felt the staff listened to them.

We observed all patients had access to their call bell and these were not left ringing. In most cases, we observed nursing staff responding to peoples needs before they needed to ring. This was because the staff located themselves in and around the ward bays and were not congregating around the nurse's station unless they had a specific reason for doing so. During our observations we saw two patients being helped to have a bath and a health care support worker had offered to blow dry one of these patient's hair.

Two people asked us for more information about when they could go home as they did not think they had been told. On checking with the staff, they said information had been given but they would talk with them again as they must have forgotten. We observed one of these interactions and found the nurse treated them with respect and reminded them about their discharge plans.

We heard nurses asking patients their views and preferences, for example, if they wanted a drink and if so, what would they prefer. We also observed one patient who was very reluctant to eat anything but the staff knew that they liked puddings so offered him something he might prefer. One patient said they had been given some written information about a test they were going to have. They also said that the doctor had told them about the test, why they needed it and what would happen. This patient also told us "the doctors are great and don't talk down to you, they explain things."

Other evidence

Staff told us that they were aware it was important to ask people about their likes and dislikes and not make any assumptions. They told us that they spent time with patients to get to know them which, in turn, helped them to deliver good care. We saw an example in a care record where the staff had gained information about likes and dislikes from a relative as the patient was unable to express their needs. Staff also said they have picture cards that they can use with patients who have difficulty communicating.

The wards had weekly multi disciplinary team (MDT) meetings in place. In response to feedback from patients and relatives, one of the wards always had a registered nurse allocated to talk with patients and/or carers and relatives following the meeting. This also provided people with an opportunity to highlight any issues that they would like to be considered by the team. The ward sister told us it had been a very effective way of making sure that communication between patients, relatives and the multi disciplinary team was effective.

We found evidence in the care records that patients had been involved in decision making about their care. For example, in one set of records we saw that decisions had been discussed with the patient and their relatives. We also saw that do not resuscitate decisions were recorded and had been discussed with the patient and their relatives where appropriate.

The trust had a dignity in care policy in place and staff told us they were aware of this. Training was available but not all staff told us they had received this. A junior doctor told us they had received training on dignity in their medical training. All new staff attended a mandatory induction that included a session on dignity in care. The wards employed clinical educators whose role included privacy and dignity issues. The clinical educator sessions did not always take place due to the wards being short staffed, but a ward sister told us this should improve as all vacancies were now filled. A ward sister also told us that she would aim to have some super nummery sessions working on the ward with her staff to ensure that patients were being treated with dignity and respect. The ward sister told us that it was important for her to act as a role model.

A doctor told us that she was mindful of talking to patients behind the curtains as people could hear what was going on. The doctor went on to say that although they would use hushed voices where possible, it was at times impossible to deliver care without other patients hearing. Where possible the ward quiet room was used for discussions with patients and or their relatives.

The patient care plans that we looked at were mixed and some records contained only brief assessments and had no care plans. Despite this, we did not find that the outcomes for people had been affected. The trust is currently implementing a comprehensive health records improvement program which included a project called “take note.” The objective of this project is to implement a revised clinical record for all adult in-patients during their stay within the trust. We observed a marked difference in these new records and found them to be very detailed and comprehensive. Patients had detailed care plans in place that were evaluated regularly. These new records also demonstrated that staff had discussed the plans of care with the patient and / or their relatives. Staff were currently undergoing training on the new system and support was being offered to make sure they were confident in its use. Regular auditing will take place to check the quality of the records in due course once all staff have received training. We found detailed assessments undertaken by occupational therapists recorded in the care record which were centred on the holistic needs of the patient.

We found that the nursing staff had a good level of knowledge about the patients they were caring for. For example, we found an entry in the nursing notes that demonstrated staff what a nurse had done to care for a patient who had been very upset. We heard staff talking with patients and engaging with them in a positive manner. We observed that many of the patients looked happy to be chatting with the staff. Those patients who could not engage in conversation very easily were also included, for example, we saw one patient who was confused but they were talking with a nurse about where they used to live when they were a child.

We saw that mental capacity assessments were completed on patients who were confused. Mental capacity is about people’s ability to make decisions and a person lacks mental capacity when they don’t have the ability to make decisions for themselves. Evidence was seen of the cognitive screening tool mini mental state examination (MMSE) being used and the results were documented in both the nursing and medical sections of the care record. Cognitive screening tools are used

to check if people have problems like dementia which could indicate they don't have mental capacity. A doctor told us that the MMSEA tool was used a great deal on the wards to assess people. The trust employs a mental health liaison nurse who provides support to both patients and staff on issues around capacity. There were no patients on the wards that were subject to the deprivation of liberty safeguards. These safeguards can be put in place for patients' in hospital that lack capacity and might have their liberty deprived in order to keep them safe. The ward sister said that they knew how to make any referrals. Staff told us they were aware of the Mental Capacity Act (2005) and would get support from other professionals such as the liaison nurses or occupational therapists if they needed more support.

In order to help meet the needs of people who have a learning disability, the trust had specialist nurses who offered support to patients and staff. They helped patients' complete a "this is me" leaflet to help the patient explain their needs and preferences to the staff caring for them.

The ward sister told us there are patient representative support groups in place for people that have had a stroke or a heart attack and we saw details of these on display.

The trust recently held a "dignity in dementia care conference" which was aimed at healthcare staff to help them develop knowledge and skills in relation to providing dignity in dementia care.

We observed information displays on the wards relating to different topics such as healthy eating and diabetes. On one of the wards we saw a display about the staff uniforms but this was not in a prominent area of the ward and it would not have been seen by many patients or visitors.

Doctors told us that peoples advanced decisions to refuse treatment were taken into account and any do not resuscitate decisions were discussed with the patient and relatives. We saw evidence of this in the records we reviewed.

We did not find information on the ward about how patients or relatives could make a complaint, although most of the staff we talked to knew what to do if a patient asked them how to make a complaint. The trust were aware that more information was required across all of the hospitals and were in the process of addressing this.

Both of the wards had suggestion boxes in place and there were posters encouraging staff, patients and visitors to the ward to make comments about their care. This prominent display also contained responses to the suggestions that had been made.

The hospital was in the process of setting up a dignity in care group which carried out visits to the wards and gave feedback about how well patients were being treated. There was also a trust wide Patient Council group who visited the wards and talked with patients. They would then raise any concerns with the hospital matron. We did not receive any concerns about the hospital from the Patient Council when we met with them earlier in the year.

Each ward had a dignity champion in place whose role it was to promote all aspects of dignity in care within their clinical area. The ward sisters told us that their dignity champions are in the process of putting together ward information books for patients and visitors. The books will contain information about the staff uniforms, meal times and visiting times as well as how to raise concerns, compliments or complaints.

We observed a wide range of information leaflets by the Stroke Association on the stroke ward, These leaflets were accessible to patients and were tidy and well stocked. One patient told us they had accessed some of the leaflets.

The trust is in the process of implementing a new patient experience monitoring tool which aims to capture the experience of patients whilst they are in hospital. At present, the hospital carries out patient surveys, but staff were not able to tell us if they received information about the feedback from patients. There was a trust wide forum where lessons leant from incidents, near misses or complaints were shared with clinical teams. Staff could not recall learning from incidents that had happened in different parts of the trust.

Our judgement

People who use the service usually have their dignity, privacy and independence respected and are treated with respect by the staff looking after them. Most of the time they are involved in making decisions about their 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

Our judgement

The provider is compliant

With outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
Patients told us that meal times were very clam and the food was always warm enough and they always got the help they needed to eat their meal. Generally the food appeared appetising and was at the right temperature. The majority of the patients said they enjoyed the food, but one patient said that the pilchards served on the day of our visit were very dry. Several patients told us there was a good choice of food, but one patient said there could be more choice. The menu rotates every two weeks and there are a number of choices on any given day, despite this, several staff said they thought the menu was repetitive for patients who were in hospital for a long period of time.

Patients were given a paper serviette with their meal but we observed that the meals were not served on a tray; they were placed directly onto the patients table. The tables had been wiped down prior to the meals being served. One patient chose to eat their meal in the day room but staff told us that most patients eat by their beds.

Patients told us the portion sizes were right for them. The ward housekeeping assistant said she asked patients about portion sizes so she did not over face them and equally some patients needed more food. We observed some patients receiving help to eat their meal and this was being done appropriately and they were not

being rushed. We observed patients being asked if they would like salt and pepper with their meal. We saw staff encouraging people to eat their meal but were respectful of patient's wishes if they did not want to eat. We observed one patient not wanting to eat and heard the staff offer them of a pudding instead as they knew they preferred puddings.

Throughout the visits to the wards we observed patients had access to drinks and they were placed within reach. Hot drinks were served regularly and we heard one patient asking for a cup of tea outside of the drinks round and saw that the healthcare support worker went to fetch one.

Other evidence

All patients are assessed on admission to the hospital with the Malnutrition Universal Screening Tool (MUST). This tool helps to identify patients who are either at risk of malnutrition or obese or those that are malnourished. Staff weighed patients on admission and then at intervals determined by the patient's risk. We saw patients had a MUST score in place and then a care plan had been developed to meet the patient's needs. We found one set of records where the doctor had requested daily weights to be recorded, but this had not been carried out, but we saw other records where people's weight had been monitored and documented. We saw that some patients had fluid balance charts in place and these were completed throughout the day. A doctor told us that the nurses pass on information about any concerns relating to nutrition to them and they will request that a referral is made to the dietician. One member of staff said that they felt that the nursing staff should be able to refer directly to the dietician, instead of requesting this through the doctor, however, the hospital managers told us that dieticians will accept referrals from any registered professional on the ward.

The wards had protected mealtimes, which means that all of the ward staff are involved at mealtimes to provide support and assistance where needed and there are no unnecessary interruptions for patients. The doctors and other health professionals were aware of this policy and said that they would not disturb patients at mealtimes unless it was absolutely necessary. Patient's relatives were allowed on the ward at mealtimes only if they were helping a patient with their meal.

We saw healthcare support workers were very involved with mealtimes and the ward housekeeping assistant said that she would not serve a meal to a patient who needed help unless a member of staff was available, that way the patient's meal did not get cold. We observed the registered nurses used the protected meal time to write up their records. They told us that they tried to use this time to catch up on their record keeping but if there were patients who needed help this would be their priority. We did observe the registered nurses checking what their patients had eaten and recording this on food and fluid balance charts. The protected mealtime policy states that registered nurses should be involved in the meal time.

To ensure the needs of patients who need help with eating are met, the wards have red trays on which the meals are served. A red tray indicates the patient needs help to eat or they are at nutritional risk. Staff can see at a glance who needs help or which patient needs a food chart completing. We did not see any red trays in use on

ward A and were told that they were in short supply. More red trays were on order but there had been a delay sourcing these from the supplier. Despite the lack of red trays, we observed that staff knew who needed help and support and the nursing staff were communicating with the ward housekeeping assistant who was serving the meal. The meals were served in an organised way and the ward housekeeping assistant lead the serving of the meals efficiently.

We did not see any patients were given hand wipes to cleanse their hands prior to eating their meal. We were told that they usually had wipes but they were out of stock. The ward sister told us she would address this straight away. We did not see staff offering alternatives for patients to wash their hands. On the second ward we visited there were hand wipes in stock and the staff told us they used these before each meal.

The meals are served from a trolley and the temperature of the food is checked by the housekeeping assistant. We were told that they alternate which bay of the ward they commence the food service so that the same patients are not waiting until the end. The main course was served first and once all patients had been served, the trolley went round the ward again to serve the desert.

We observed that adapted cutlery was available to help people eat their meals and we observed one patient using a plate guard. One patient who only had the use of one hand was eating their meal with a spoon. There was no plate guard in use which could have been beneficial for this patient, but despite this, we observed that the patient had eaten their meal. Staff were clearly knowledgeable about which patients' needed help to eat and drink or those that had particular needs. In addition, we also observed those patients who were nil by mouth receiving mouth care.

The ward housekeeping assistant told us she had received some training on nutrition and was aware of the importance of good nutrition to aid people's recovery. She knew about how to complete food charts, and had knowledge of the menus that were on offer. She told us that she felt the smooth diet food, which was used for patients who had swallowing difficulties, was not very appetising. The housekeeper told us that she receives a hand over from the nursing staff and she felt very much part of the ward team.

Nutrition is covered as part of the trusts mandatory induction programme. In addition, other types of nutrition related training were offered. For example, most of the registered nurses on the two wards we visited had received training in dysphagia assessment. Dysphagia is a term used to describe someone who has difficulty swallowing. Staff told us that due to a vacancy, there was no access to a speech and language therapist at the weekends so they had to rely on the nurses who had received dysphagia assessment training. Staff were aware that there could be other factors could influence weight loss, such as high doses of diuretic (medicines that remove water from the body). Staff were aware that poor nutrition is linked to a range of health problems, for example, one nurse told us a patient who would not eat very much was being offered food supplement drinks and puddings to help their leg wounds heal.

Some staff told us that although they thought the food available was fairly good, they would prefer to see meals cooked on site using local produce. The trust told us that they sourced local produce where possible. Meals were prepared on one of the other hospital sites and were then taken to Grantham hospital to be heated up. The same food is served to staff in the staff restaurant. Staff also said the staged diets were not very palatable but these were served as food groups, rather than all together. For example, potatoes, meat, vegetables were served separately. Staged diets are used for people who have swallowing difficulties and require their food to be served at different consistencies. The staff said progress with staged diets had been made, but more could be done to improve them.

Staff told us that if a patient misses a meal they could access food out of hours. They also had facilities on the ward to make simple snacks such as beans on toast. The ward housekeeping assistant told us if a patient was admitted to the ward after the menu choices had been made, they would still be able to offer them a choice of meal.

We observed food charts were being maintained throughout the day and they were completed accurately. The dietitian told us that generally they are well maintained.

We looked at care records there were links made between the patient's clinical problem and their nutritional risk. For example, one patient had a wound to their legs and the MUST assessment and care plan reflected this and described the need for nutritional supplements to help the wounds to heal. The dietitian told us that this patient had been referred to them because of their nutritional risk.

We found evidence in one patients file that weekly MUST scores had been completed in accordance with the hospitals policy. Swallowing difficulties had been identified and were included in the patient's care plan. A dysphagia assessment had been completed and the patient had been referred to the dietician. Food charts had been completed and there was evidence that the patient's care had been evaluated. There was no evidence that the patient's food preferences had been recorded, but the type of diet the patient required was highlighted following their swallowing assessment.

We looked at the care records of a patient who was receiving nutrition via a feeding tube because they were unable to swallow. On admission the MUST score was recorded and a swallowing problem was highlighted. A swallowing assessment had been completed and a naso gastric feeding tube had been inserted. This tube goes through the nose and into the stomach and delivers liquid food that is nutritionally balanced. We saw evidence that this had been completed within 24hours of the patient being confirmed as having had a stroke which was in accordance with the guidelines issued by the National Institute of Clinical Excellence (NICE). NICE are an organisation that provide national guidance on the best treatment for people with certain conditions such as a stroke. We also noted that the dietitian was involved and feeding regimes had been clearly documented. Nursing staff had consistently recorded the timing of the feeds and the amount given. Once it was established that the patient required long term nutritional support, the patient had a percutaneous endoscopic gastrostomy (PEG) inserted which is a tube placed directly into the stomach through the abdominal wall. This was also in accordance with NICE

guidance.

We found one set of care records where a MUST assessment had identified a patient was at nutritional risk and a note was made that a food chart was to be commenced and nutritional supplements should be offered. However, there was no evidence in the records that nutritional supplements were given. We followed this up with the nurse looking after the patient and were told that they had been given but had not been documented.

Patients choose their meals from a menu card for the following day. The menu cards are detailed and gave pictures of the meals. We also saw large print booklets with pictures of the meals so that the staff could help people make choices. The ward house keeping assistant said she helps patients' choose their meals. If a patient changed their mind about their meal, it could usually be accommodated. She also told us that she talked with patient's families about their likes and dislikes and tried to get to know the patients' as much as she could. We observed the housekeeper chatting with patients' during the drink rounds.

We observed a set of care records that stated the patient's food preferences, this patient also had a detailed care plan in place for nutrition. However, we found in another set of records an entry that read "normal diet and fluids taken," but there was no indication of what normal was for this patient.

We did not talk to any patient who had their food prepared in a particular way but we observed that there were kosher and halal meals available on the menu cards should they be required.

We observed in one care plan that the patient had stated he would prefer his family to assist him with his meals so the nurse had talked with his family to make arrangements for different family members to accommodate this.

Our judgement

People are supported to have adequate nutrition and hydration and are given choices to meet their needs. The risks of poor nutrition and dehydration are identified by staff who understand people's needs.

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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