Dignity and nutrition for older people

Review of compliance

East Sussex Healthcare NHS Trust

Eastbourne District General Hospital

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<th>Region:</th>
<th>South East</th>
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<tr>
<td>Location address:</td>
<td>Eastbourne District Hospital</td>
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<td>Kings Drive, Eastbourne,</td>
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<td>East Sussex BN21 2UD</td>
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<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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<td>Overview of the service:</td>
<td>Eastbourne District General Hospital is located on the outskirts of Eastbourne town centre on one of the main thoroughfares into Eastbourne. The Hospital has commanding views of the town and its rural locality. The hospital provides a comprehensive range</td>
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of acute surgery and medicine, for all ages.

medical and surgical wards
Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Eastbourne District General Hospital was not meeting either of the essential standards we reviewed. Improvements were needed.

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 the 09 May 2011.

We observed how people were being cared for on two wards, Hailsham 3 and Pevensey Ward. We talked with 10 people who use services, three visitors and seven members of staff, checked the provider’s records, and looked at records of eight people who use services.

The inspection teams were led by CQC inspectors and 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

Some of the patients spoken with and three visiting relatives told us that they were in the main satisfied with the care and treatment they received at Eastbourne District General Hospital. They said they had been treated with courtesy and respect and that their privacy and dignity had been promoted and well-protected whilst receiving personal care.

Direct quotes include “Very helpful and kind” “Always lower their voice when giving me personal care” “Pretty good, staff are well meaning, I find it very hard to sleep because it is so noisy”.

Other patients spoken with were not so positive about their experience in hospital. One comment received from a patient indicated that her experience was mixed, “Can not complain, staff kind but meal times are a nightmare for me, last week they insisted on feeding me, this week they aren’t, if I could reach my meal I could feed myself. “

The feedback about the quality, range and availability of food was mixed. Breakfast was said to be the best meal of the day, and supper was the worst. The feedback taken from the medical ward was that patients indicated that the meals were very nice and appetising at lunchtime, although the vegetables were often overcooked. “Its fine” “Breakfast is my favourite” “The vegetables are always overcooked and tasteless” “Not bad, but I am not here just for the food” The same standard was not described as acceptable at suppertime. The patients commented on the lack of choice, pasta dishes overcooked and often unpalatable, “The supper is terrible” “I’ve put on weight, because I am eating so many biscuits and cakes”. The surgical ward patients said “Too heavy and stodgy” “I can not eat that” “Good food, but not always the hottest”
What we found about the standards we reviewed and how well Eastbourne District General 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.

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

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

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 moderate concerns with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

Ten patients and three relatives were spoken with during the visit. We also observed the care provided to patients. Prior to making the visit we looked at the feedback provided by patients on the NHS Choices website, the hospital analysis report and other information provided by the Trust. We also looked at action plans provided by the Trust following an inspection in February 2011. We were told that recent patient survey results were not yet available.

One patient told us that he felt “They do their best and under difficult conditions”. It was mentioned by one patient that they found a night nurse abrupt and had asked that they not care for them in future; the patient stated that this had been arranged. The patient and relative did not know that there was a complaint system in the hospital that they could access.

Feedback from patients and their relatives on the medical ward confirmed that
hospital doctors, consultants and ward staff provide clear advice and information to patient about their health needs, risks and the management of their condition. They said that they felt that they were listened to and spent time explaining what was happening. Patients said they were encouraged to ask questions and to be actively involved in decisions about their care. Relatives said they had been kept well-informed and that their involvement had been welcomed. The feedback on the surgical ward was not as positive, and this was due to the mental frailty of some of the patients.

Patients told us they had been asked what they wanted to be called on their admission to hospital and that this was respected throughout their stay, however this was not reflected in some care documents. One patient said “They asked me what I want to be called, I found that really nice as it made me feel welcome” We found that patients did not have their names written up over their beds, but displayed on a whiteboard in the ward corridor.

We found that staff were positive about and open to patient feedback. We were told that everyone was encouraged to complete a survey following their discharge from hospital. It was not clear from talking to patient whether they knew the process to give feedback. One patient said the feedback form was given to him in pre-admission information pack, whilst another said “Not aware that there is a form I can fill out.”

Other evidence
The information we held about Eastbourne District General Hospital prior to our visit showed that there was a high risk that they were not meeting this standard. Recent visits and reports of health care practices undertaken by the CQC denoted past weak performance by Eastbourne District General Hospital site in respecting and involving patients who used its services. Action plans had been put in place to address areas where performance was not yet delivering the required standards or outcomes.

The hospital doctors, allied health professionals and nursing team work together to meet the health and physical needs of their patients. Feedback from some patients and one allied health professional on the surgical ward identified that the patient’s mental health and social needs are not being fully explored and risk assessed to ensure that their dignity and independence is respected.

A senior staff member interviewed on the medical ward had a particular interest in privacy and dignity and said that all staff is aware of promoting their patient’s privacy and dignity, but had not received specific training in this area. The feedback on this ward from both patients and relatives was very positive.

We looked at eight patient’s records and found overall that they were not maintained to a satisfactory standard. Individual faith, ethnicity, personal preferences, mental capacity and home circumstances were not recorded in full or consistently on any of the care files reviewed. The patient’s profile sheet was found in most cases only partially completed and therefore this information could not be used to inform the delivery of care. There were no clear systems in place to identify patients who were mentally frail and in some daily notes there was reference to agitation and confusion.
but no care plan put in place to monitor or explore the reasons for this identified problem. The lack of information about mental health problems, mental capacity and past history does not give staff the knowledge they need to care for the patients.

We saw that dignity and privacy was not always adequately protected or promoted on the surgical ward and not all patients were being offered the choice to be taken to a bathroom or shower room for a wash, bath or shower. Some people were not taken to a toilet away from their bed space, and commodes were used frequently and the process could be heard throughout the bed areas. Commodes were also noted to be taken to people’s bed space at meal times.

Discussions with two elderly patients, both female, stated that they had had to refuse personal care as they did not want a man to wash them or to place them on a bedpan. They were not asked their preferences on admission to the ward. One care plan made no reference to this having been raised and the other had it written across the front of their care plan.

Some people were observed to be left in a chair by their bedside with little understanding demonstrated that they could not reach their belongings and drinks easily. This was seen to impact negatively on people’s choice and dignity and resulted in spilt drinks and stained clothing.

The staff receive a verbal handover which is used to help ward staff understand and provide consistent support to patients on the ward. However it did not clearly identify those on the surgical ward who have difficulties in communicating or adapting to a ward environment and therefore would not provide a consistent and person centred approach to individual care.

There was limited information or references made to people’s communication needs in the plans of care viewed. Some bank staff were seen to struggle to communicate effectively with some people especially those that were confused. This was particularly evident in the meal service and when undertaking personal care.

By direct observation, personal care tasks were undertaken behind curtains, not all staff asked/checked before entering and there were no discreet sign on the curtain to alert people that personal care was being undertaken. Other health professionals (e.g. Physiotherapist) that were giving direct treatment were observed to be courteous, supportive and maintaining patient’s dignity.

Men and women did not have to share accommodation or bathroom facilities. There were signs in place to promote awareness. However it was noted on the surgical ward that the male toilet was opposite the female bays and the female toilet opposite the male bay and the doors are left open when not in use, thus not guiding patient to using the sex designated toilet.

Call bells for the majority of patients were left within easy reach so patients could easily summon help when required. The response to call bells was usually quick, but twice during our visit we noted that the call bell was answered promptly and then
the patient was told “I will be back”. Both times it was approximately 15 minutes until the staff came back.

From direct observation there was evidence that on the surgical ward that the patient’s mental health and social needs are not being fully explored and risk assessed to ensure that their dignity and independence is respected.

Care and treatment plans focused on promoting patient’s recovery and any ongoing concerns were closely monitored. Some records however, could have provided a clearer picture of the patient’s views and wishes. Auditing of patient records was undertaken as part of the Trust’s ongoing commitment to raising standards. There was no clear evidence that actions are taken as a result of audit activity.

There was a range of advice and information leaflets for patients. There was guidance on help available at the point of admission and following discharge from hospital.

All patients are offered the opportunity to complete a questionnaire when being discharged from hospital. The data collected does not indicate which ward the patient had been discharged from. Although this is meaningful data for the Trust to collate patient’s views and comments it does not allow for any issues or trends to be isolated to any specific clinical area and therefore makes it difficult to improve on the services or deal with specific issues relevant to the area.

Our judgement
During the inspection of two wards at the hospital we found that there was a clear disparity in management, practices and the way that people’s care, treatment and support were made available to them.

Some patients who were able to share their views were very positive about their experiences of care and treatment at Eastbourne District General Hospital. They told us their individual needs had been recognised, that they had been respected, and that they were well-informed about their care and rehabilitation arrangements. However this was not evidenced in the individual care documentation and was not observed in practice for those who were unable to discuss and be actively involved in their care.

Overall, we found that Eastbourne District General Hospital was not meeting 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

Our judgement

There are moderate concerns
with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

When we asked patients about the protected meal times and if they felt that the environment and atmosphere was appropriate for them to eat uninterrupted, the response from the two wards was very different. Patients said the medical ward was “Nice and calm, organised but relaxed”, whilst the surgical ward was said to be “Too noisy, everyone busy and hectic” “Feel like I am supposed too rush, don’t get time to enjoy” “Is it a protected time?”

Patients said they were not offered hand hygiene before meals. However during the visit we observed a health care assistant in the first bay offering wet wipes, before meals but not after the meal. This was not observed in other bays.

Patients confirmed they are asked their preferences from a menu each morning and were encouraged to select the meals they liked. However not all patients had remembered their choice and when given the meal expressed disappointment, “I don’t fancy this at all. Did I really order this”?

Overall, we found that there were concerns identified about food and mealtimes from patients.
Other evidence
From direct observation we saw that not all staff recognised patients’ dietary needs and preferences and give appropriate support to those needing assistance. Assistance was not always given in a timely manner and following good practice guidelines. This refers in particular to those patients who were confused and lacked capacity.

From direct observation (specifically seen on the surgical ward) the amount of food cleared away uneaten was high. Three patients in particular did not touch their lunch at all. There was no evidence that this was documented or that staff paid particular attention to the amounts not eaten.

When asked what was offered to those that had not eaten, the staff member said, “Oh have they not eaten, I will make sure they are offered something”. One patient was seen to be offered a plate of chips which the housekeeper had got from the staff canteen. The patient was seen to really enjoy the finger food. We asked staff if finger food could be specifically requested and the staff were not sure if this could be arranged.

Drinking glasses and water were placed on the bedside tables on both wards and regularly refreshed. However not all patients could reach their glass and not all could drink from the glass provided without help.

We observed that the housekeeping staff served the meals appropriately and endeavoured to make the meal look appetising. It was evidenced on the medical ward that food supplements and thickened fluids are provided as required to those that had been identified as at risk. Staff on the medical ward were observed sensitively supporting patients who were in pain or feeling nauseous and recognised the impact this might have on their appetite and overall levels of nutrition. Snacks were said to be offered to patient who had missed meals.

We observed that five patients on the surgical ward who needed assistance did not automatically get the support required. When attention was drawn to the difficulties some patients were having, assistance was given, but not in a timely fashion and only on prompting.

It was noted that there were insufficient staff and lack of direction from senior staff to ensure that those patients who needed help and encouragement to eat received it.

There was evidence of good practice seen by some staff when assisting patients, in that they sat next to them and took time to ensure they were swallowing and finishing their meal. However poor practice was also observed by staff sitting on the patient’s bed and leaning over them to assist and also of staff standing over them and feeding them. It was also observed that a staff member would start to feed them and then leave only to return some fifteen minutes later. This meant a tepid/cold meal. The hot pudding was served at the same time as the main dish and again not eaten by some patients for up to half an hour later. A diabetic meal was served first, identified from a sticker in the hot trolley.

It was noted that there was no signage at the ward entrances indicating that protected mealtimes was in place, although the staff did talk about protected mealtimes being in place. The staff all stated that it was standard practice on the
ward and all multi-disciplinary staff were aware of the expected standard. It was noted that that patients received their medication during the meal service and also in one case physiotherapy. Patients were placed on commodes by their bedside as meals were being served in the bay.

We noted that adapted cutlery and crockery was not available for patient who required this. We saw patients struggle to eat without the necessary support and equipment; Tables were too high for patients to reach, lack of plate guards and lack of specialised cutlery. Other patients were left with food they were unable to eat or cut up and were not offered a napkin to protect their clothes.

We were told that equipment had arrived and is ready for dispensing to the wards. Patient with additional support needs were not supported via an internal system for staff awareness such a red trays or discreet sign or sticker.

From viewing individual care documentation weight loss and special dietary requirements were recorded at the point of patient’s admission to hospital on the medical ward but not in all the care plans seen on the surgical ward.

Care documentation did not all clearly reference mental capacity and whether an advanced care decision had been made in respect of nutrition or the need for specialist advice. Patient records identified some inconsistencies in the use of the Malnutrition Universal Screening Tool (MUST). Some were not completed at all and this included two whose fluid and food charts identified that meals and fluids were being consistently refused. There was limited follow through recorded and no dietary supplements requested.

Food and fluid balance charts are in use, but not completed in full and in some instances not followed through with appropriate intervention and cross referenced in the care plan. This then does not inform the care given and required. Staff were not always aware of patients who were not eating or drinking a sufficient amount on the surgical ward and the food charts were not always completed consistently.

The need for artificial feeding was found to be carefully considered and the patient and their family were kept informed about individual risks and options. There was evidence on the medical ward that patients about whom there were concerns were being promptly referred to a Dietitian or speech and language therapist (SALT) for specialist advice.

**Our judgement**
The quality and range of food provided was not of the standard expected for all meals. There was consistent feedback from patients who use the service that supper meals were inadequate.

During the inspection of the two wards we found that there was a clear disparity in management, practices and the way that people’s nutritional care, treatment and support were made available to them. On one ward not all of the patients who required assistance received the necessary level of support. The documentation in place to monitor and identify nutritional problems was not consistent and did not always promote the safety and well being of the patient’s who
use the service.

Overall, we found that Eastbourne District General Hospital was not meeting this essential standard.
Compliance actions

The table below shows the essential standards of quality and safety that are not being met. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>17</td>
<td>1 – Respecting and involving people who use services</td>
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<tr>
<td>Diagnostic or screening services</td>
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<td>How the regulation is not being met:</td>
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<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.
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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### Care Quality Commission

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| Postal address           | Care Quality Commission  
                          | Citygate  
                          | Gallowgate  
                          | Newcastle upon Tyne  
                          | NE1 4PA |
