Dignity and nutrition for older people

Review of compliance

Shrewsbury and Telford Hospital NHS Trust **Royal Shrewsbury Hospital**	
Region:	West Midlands
Location address:	Royal Shrewsbury Hospital Mytton Oak Road Shrewsbury SY3 8XQ
Type of service:	Acute Services
Publication date:	June 2011
Overview of the service:	Royal Shrewsbury Hospital is part of Shrewsbury and Telford Hospital NHS Trust. The trust is the main provider of acute hospital services in Shropshire, Telford and mid Wales and provides acute care for a population of almost 500,000 people from across Shropshire and Mid Wales. The trust has two main hospital locations in

	Shrewsbury and Telford, with a range of community hospital based maternity units across the area. The Royal Shrewsbury Hospital provides 544 beds. The acute hospitals provide emergency services, medical and surgical investigations and a full range of diagnostic facilities and medical treatments for physical illness or condition, injury or disease. Further information about the trust is available on their website which is: www.sath.nhs.uk

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

What we found overall

We found that Royal Shrewsbury 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 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 team was led by CQC inspectors joined by a practising, experienced nurse. The inspection team also included an 'expert by experience' – a person who has experience of using services (either first hand or as a carer) and who can provide the patient perspective.

We reviewed all the information we hold about this provider, carried out a visit on 29 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, ward 27 and ward 28. Ward 27 is an acute medical ward and ward 28 is a trauma/orthopaedic ward. During our visit we looked in detail at the care five older people were receiving. We spoke with them and a visiting relative. We also spoke with a number of other older people receiving services in addition to eight staff from different disciplines. We spent time on both wards observing how people were supported at lunchtime to eat their meal.

What people told us:

Overall people told us that staff involve them in their care, treatment and support and that their privacy and dignity is respected. Most people told us that staff call them by their preferred form of address and respond to their needs quickly. They said that

staff are kind and explain what they are doing. One person said, “The staff are very careful how they handle me” another person said, “One time I was being washed and they left me in the middle of my wash to attend to someone else. I was left about half an hour”.

People said they are offered a good choice of food but this is not always the option they actually receive. Most people told us they felt their nutritional needs and dietary preferences were well met. All but one person we spoke with was happy with the food portions and how their food was presented. One person said, “I’m quite impressed with the food and the care is fantastic. The staff are very good at offering lots of drinks. They really are doing it very well”.

What we found about the standards we reviewed and how well Royal Shrewsbury 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 Royal Shrewsbury 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 Royal Shrewsbury 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 five 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 with a number of people across the two wards that we visited. Overall people expressed their satisfaction with their care, treatment and support. Most people told us that staff respond to their needs quickly although one visitor told us that they had to frequently wait for a long time when they called for a nurse to assist their relative to go to the toilet. One person told us that staff had explained about their treatment and what was happening to them. They said that staff check to see if they are feeling alright and said “Nothing could have been done better, I’m very satisfied”. Another person said, “The staff are kind, very good and dedicated. They don’t do anything to me without drawing the curtains”.

One person told us that he was worried about how to use the bedpan and when he asked staff they made a comment that he considered rude. We saw the bedpan had been left on the bed and the person didn’t appear to know what he was supposed to do with it.

Other evidence
The trust has confirmed that it is compliant with the Government’s requirement to eliminate mixed-sex accommodation, except when it is in the patient’s overall best interest, reflects their personal choice or when clinically necessary. Staff showed us

round the two wards we visited and we saw plenty of facilities available to suit the gender of people in the bays. Each bay is restricted to single sex occupancy with notices displayed on the entrance to each bay and designated bathrooms and toilets located nearby.

In early 2010 the hospital received an overall rating of 'excellent' for modesty, dignity and respect awarded by the Patient Environment Action Team (PEAT). This was an annual assessment coordinated through the National Patient Safety Agency (NPSA) to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity. Assessments are carried out by NHS staff, as well as groups of patients, their representatives and members of the public and each hospital is given a score of excellent, good, acceptable, poor or unacceptable.

We observed how staff respected and involved older people in their care across both wards. People looked well cared for and staff talked to them in a respectful manner, explaining and offering reassurance where necessary. However, during our visit, we saw one member of staff administer medication to one person without any verbal communication with the person concerned, such as what they were doing or why. Another patient told us he was moving to another ward but did not know the reason for his move. We saw his bags packed on his bed ready for his transfer.

Overall we observed staff promoting people's privacy and dignity for example timing of personal care, lowering their voices when discussing sensitive issues or care, using curtains to ensure privacy and adjusting their position to be level with individuals. We observed staff taking time to listen to people and supporting the more frail patients and involving them in their care routines. We also saw some practices that compromised people's dignity. We saw one person sat on the toilet with no clothes on with the door left wide open. We saw one person being administered an injection in their stomach at lunch time without privacy screening between them and the person next to them who was eating their lunch. We also saw a person sat on a commode with a large gap left in the privacy curtains.

Observations across the wards showed that not all older people had their call bells near them as they were behind chairs making it difficult for people to see or reach them. This meant it would be difficult for people to ring for help if they needed it. This had been highlighted as an area needing reinforcing on ward 28 following an internal quality review visit undertaken by two senior nurses in January 2011.

We looked in depth at the care five people were receiving across two wards. We discussed their care with them and reviewed their records. Four of the five records reviewed contained detailed information about the choices and preferences made by the person about their care. We saw people's religious and cultural needs also recorded. However, we saw on one person's medical records that a completed 'Do not attempt to resuscitate' (DNAR) instruction was held on their notes which had been made on a previous admission to the hospital. This had not been reviewed with the person concerned on their latest admission. When we spoke with staff they informed us that the person would now be for resuscitation and has capacity to make decisions, but this had not been documented. We spoke with the trust about this and we have since received confirmation that this has since been reviewed. They also told us that they will provide team training on mental capacity and specific

training in relation to DNAR.

An assessment of each person's mental capacity to make decisions about their care was not available on all the care files sampled. One care plan stated the person was, 'confused and disorientated' but nothing was documented about who would make decisions, such as their next of kin or lasting power of attorney. Not all of the staff we spoke with have received training in the Mental Capacity Act legislation and the trust has acknowledged this is an area for improvement. During our visit one person, who has dementia, became verbally abusive towards a nurse when they were informed that their medication was due. The nurse was softly spoken, non-confrontational and responded well to the person concerned. Following our visit we raised a concern with the trust in relation to this person. The information held on their file and which we clarified with a member of staff identified that the person had been restrained in order to take a blood sample. No assessment of capacity had been undertaken but staff had completed a best interest form about restraining the person to relieve their position in bed and cleanse their skin. The trust has since told us that they have taken action to address this concern and that they will develop a policy framework for the use of restraint.

We asked people about the information they had received when they arrived at the hospital about facilities, mealtimes, visiting times and what to do if they are unhappy with their care. Most people spoken with told us that general information had been explained to them and that they had been provided with a 'Patient Information Booklet' but no one knew how to raise a concern or complaint about their care and this information was not provided in the booklet or easily accessible on the wards. The trust told us that 'patient information for this needs to be improved'. Not all staff spoken with demonstrated an understanding of the trust's complaints procedure and the majority of people spoken with were unaware of the Patient Advice and Liaison Services (PALs), which is a service located within the hospital and provides a range of support information to people using services and their relatives.

The majority of staff spoken with considered they have enough time to provide personalised care although one person said, "It's really difficult to give proper care if the ward is understaffed, particularly in the mornings when we have to give patients bed baths. More staff would provide more effective care". Staff we spoke with provided clear examples of how they promote independence and decision making with the people they support. Staff told us they have access to specialist staff including physiotherapists and occupational therapists to improve and promote people's independence. They told us if an individual does not have capacity they talk with them, observe reactions and check out their likes and dislikes with family members who know them best. This helps them to gain a greater understanding of each individual.

Staff spoken with confirmed they had received training in privacy and dignity through their induction, with study days and information available on the staff intranet. A Dignity in Care Conference is also being organised for May 2011. One member of staff told us they had also recently undertaken a lot of self research on privacy and dignity. They considered the training had reinforced their knowledge and skills and provided them with confidence "to get it right". Another member of staff rated their ward well at promoting privacy and dignity but felt improvements could be made.

Information we hold about the trust indicates that there are a range of methods in place to collect the views of the people who use the service. These include surveys, ward assurance reviews, evidence of people's involvement from care planning documentation and ward handover involving people directly in their care. They told us that they have a wide range of information leaflets which help people in their decision making. However our observations show that more attention needs to be given to ensure these leaflets are always available.

Besides obtaining views of people during our visit we also looked at NHS Choices which is a website where people can post comments about the service they have experienced. One day patient in May 2010 remarked on the dignity and respect shown to her and a patient at the medical assessment unit in January 2011 reported staff as sympathetic and caring and also that, "other patients with social and dependency problems were treated with great respect."

The Telford and Wrekin Local Involvement Network (LINk) have recently visited the Royal Shrewsbury Hospital. LINk is made up of individuals, community groups and voluntary organisations with an interest in improving health and social care services. They work closely with the primary care trust (PCT) and local authority to ensure people's needs are met. LINk representatives visited people on four wards (different from the wards we visited). Feedback gained includes one person having to help other people at times when there was not enough staff available on the ward. Two people felt that privacy, dignity and respect were good. Two people expressed concerns about staff talking and laughing during the night preventing them from getting their sleep.

A privacy and dignity patient survey has recently been undertaken across the trust to gain patient experience. The draft document was shared with us and includes a summary of the findings, areas of improvement, areas of consistent performance and areas of decline. The summary of findings states that almost nine in ten patients felt they were *always* cared for with respect and dignity during their stay.

Our judgement
Privacy is respected and the care provided is dignified for the majority of the people most of the time. Most people are involved in making decisions about their care but this is not consistent. People unable to make their own decisions are not treated equally because they do not always receive proper assessments.

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 minor concerns with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People were generally positive about the choice of meals they are offered and told us the food is always served hot. They told us that plenty of drinks are made available. They said they get the menu two days in advance and have to select their choice of food. One person told us that it can be confusing as she has often forgot what she has ordered by then but said, “It’s a nice surprise when it comes”. Another person told us that choosing meals so far in advance is ok as long as you are not moved onto another ward then the choice of food is often limited. One person with special dietary needs found her meal poorly presented and refused to eat it. One person told us that following his surgery he was offered something to eat as soon as he felt able. Other people’s experiences include: “I’ve had some lovely salads. I’m quite impressed with the food”. “The choice of food is excellent and it is much more of a positive experience than what I expected”.

Other evidence
We observed lunch time on the two wards we visited. We saw some people being adjusted in their bed or chairs ensuring they were sat comfortably in preparation for their meal. Not everyone was offered the opportunity to wash their hands prior to their meal being served or after eating and napkins were not easily accessible. Meals were pre-plated and served on individual trays to people from a heated trolley. The food smelt nice and appeared appetising. Staff responsible for serving food were seen wearing personal protective clothing.

A red tray system is used to identify individuals who require assistance with their meals. Staff spoken with were fully aware of this system. We observed people with support requirements receiving assistance from staff; however one person was

served their meal but had to wait until a member of staff had finished assisting another person to eat. One person's care file indicated that the person needed encouragement with eating but it did not state what or why.

We observed staff assisting people with sensitivity and respect for their dignity. One person, who is vegetarian, was offered a meat dish and refused this. Although an alternative main meal was offered she declined and chose to eat a soft dessert as she said she had a swallowing difficulty. Although the person's care records evidenced that a nutritional needs assessment had been undertaken, no dietary preferences were stated. Staff checked people had finished their meals and food and fluid charts were completed for people whose intake was being monitored.

On both wards we saw that people were not able to eat their meals without unnecessary interruptions. We observed people being interrupted by doctors in the middle of their lunch. We saw two medicine rounds being done at the same time people were eating. On one of the wards we saw an electrician testing electrical appliances without communicating to people what he was doing while they were trying to eat their meal. This created a chaotic, noisy atmosphere which was not conducive to promoting a positive eating experience.

Information we hold about the trust identifies that protected meal times are currently not in place and the trust recognise they need to be introduced across all ward areas. They have provided us with an action plan identifying what action needs to be taken and that the agreed date for roll out across all ward areas will be September 2011. They also provided us with a copy of the draft protected mealtimes policy.

We spoke at length to a housekeeper and she provided us with copies of the menus. These include normal diet, pureed/soft, ethnic, renal/low salt/gluten free. An additional menu is also available for people who have additional special requirements. The ethnic menu was available in a number of languages to include Punjabi, Hindi and Urdu. Menus included information about the catering services, food brought in, mealtimes, special requirements, accompaniments, hand washing and a satisfaction survey. People are required to select their meals 48 hours in advance and choose their portion size. The housekeeper told us that she offers people assistance where required to complete their meal preferences and said, "I think the food offered to patients is brilliant. They get a good choice and the food is always warm. The kitchen is very accommodating".

We spoke with a number of staff across the two wards we visited. They told us that on admission a nutritional risk assessment is undertaken on each individual and the person referred to the dietitian if they are identified at risk of poor hydration and nutrition. We saw evidence of this on the files of the people whose care we looked at in detail. Staff told us that they had received training from the dietitian in completing the assessments and considered the training and the support provided helpful. They also said they have access to specialist staff to include occupational therapist, dietitians and the speech and language team (for people identified with swallowing difficulties).

Staff spoken with said specific dietary needs and cultural needs are well catered. One member of staff expressed concerns about not having protected mealtimes on

the ward and felt this was “a big challenge” as mealtimes are very busy. Another member of staff told us that food and fluid charts could be completed more regularly, particularly by agency staff, who they consider do not complete these as often as they should. The use of food and fluid charts was also identified as an area for improvement by the trust during quality review visits in December 2010 and January 2011 across the two wards we visited. A record of food and drink was available on three of the five care records we sampled, which seemed appropriate according to their level of need.

Views of people’s experiences gained through NHS Choices for this hospital include a person who received care on a respiratory ward in November 2010. They commented that the food was excellent with multiple choices, and patients who required help to eat were assisted. A person who was cared for on the gynaecology ward in October 2010 reported finding a hair in their meal and that kitchen hygiene was, “obviously sadly lacking”. The trust has provided us with a copy of the minutes for the last Nutrition Group Meeting held on 22 March 2011. This indicates seven similar incidents were reported across the trust and the catering team are to look into these. New menus, protected mealtimes, food safety policy and nutrition screening were also discussed at the meeting.

The overall Patient Environment Action Team score for food from the NPSA from early 2010 rated Royal Shrewsbury Hospital as ‘good’.

Feedback gained from LINks following their recent visit to the hospital include:

“The food is OK but the menu choice was not followed up, therefore I received another patients choices”

“The food is not so good but I get what is requested”

“The food could be better. I do not always receive what I requested from the menu”

LINk representatives observed people being offered drinks on the wards visited.

Our judgement

People receive an assessment of their nutritional state and if necessary assistance is requested from dietary specialists. People are offered choice but this is not always the option they actually receive. Staff know which people need assistance to eat their meal and provide this help in a respectful and sensitive way. People are not always given enough time to eat without interruption which may impact on their enjoyment of meal times.

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.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures	17	1
	Why we have concerns: Privacy is respected and the care provided is dignified for the majority of the people most of the time. Most people are involved in making decisions about their care but this is not consistent. People unable to make their own decisions are not treated equally because they do not always receive proper assessments.	
Treatment of disease, disorder or injury Surgical procedures Diagnostic or screening procedures	14	5
	Why we have concerns: People receive an assessment of their nutritional state and if necessary assistance is requested from dietary specialists. People are offered choice but this is not always the option they actually receive. Staff know which people need assistance to eat their meal and provide this help in a respectful and sensitive way. People are not always given enough time to eat without interruption which may impact on their enjoyment of meal times.	

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 five 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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