

Time to listen

In NHS hospitals

Dignity and nutrition inspection programme
2012



The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we focus on:

- Identifying risks to the quality and safety of people's care.
- Acting swiftly to help eliminate poor quality care.
- Making sure care is centred on people's needs and protects their rights.

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Foreword

With life expectancy increasing, and a growing population of older people in England, the spotlight has been turned on the quality of care they receive.

CQC has already drawn attention to cultures of care that too often are ‘task-based’ when they should be person-centred, and where the unacceptable become the norm. Recently published reports from the Patients Association and our own State of Care report continue to highlight episodes of poor care.

In October 2011, we published our first report on 100 unannounced inspections of NHS hospital acute trusts, where we looked in detail at standards of dignity and nutrition on wards caring for older people. While we were able to report examples of good care, we also found that 20 hospitals were failing to meet the national standards that people should expect.

We have followed this up with two further inspection programmes looking at dignity and nutrition issues for older people. One was our first in-depth look at the experiences of older people in care homes. The other was a further programme of inspections in 50 NHS trusts, this time including both mental health and acute trusts.

Overall, we found that most patients and residents were receiving the levels of care and support that they should expect. This report sets out what was working well and describes how this was being achieved – an approach that is supported by the emerging themes from our recent consultation on our strategy. We need to report on good care, so the public can be clearer about what it is they should be expecting. Taking the opportunity to share good practice with providers should also encourage them to improve.

However, it is unacceptable that we are still finding people who are being treated and cared for in ways that fail to meet national standards, and we have reported what needs to improve. Many of these improvements are not complex or time-consuming to make, and could be addressed through changes to systems and processes, or through taking steps to make sure the right culture is created to support staff in providing care.

CQC continues to hold individual care providers to account and take action where improvements are not made. In addition, our reports are written to support providers in identifying the factors that need to be in place to make sure they are treating people with dignity and respect and are meeting their nutritional needs.

These inspection programmes were once more a collaborative effort, working with practising professionals and Experts by Experience (people with direct experience of care services) as part of our inspection teams. The first NHS hospital programme was supported by professional nurses. This time we broadened the skills and knowledge base of our practising professionals to include geriatricians and dietitians. Advisory groups of experts in the field provided advice and challenge to us throughout the process.

We are publishing two separate reports, one for the NHS and one for care homes. This report describes our findings from the inspections of NHS hospitals. We intend that these national reports will help providers, commissioners and other stakeholders to improve the care that they are responsible for and deliver a culture of care that puts people first.

David Prior
Chair

David Behan
Chief Executive

Summary

This programme of themed inspections looked at the care provided to older patients at 50 NHS trust hospitals in England during 2012, focusing on dignity and nutrition. It followed a programme of inspections of 100 hospitals in the previous year looking at the same broad themes.

Comparing the results of the 2011 dignity and nutrition review with these latest findings, we were pleased to see that broadly more hospitals were meeting people's nutritional needs. In 44 out of 50 hospitals (88%), patients were given a choice of food and drink to meet their nutritional needs and given help to eat and drink when they needed it. The corresponding figure in 2011 was 83%.

On the other hand, there were fewer hospitals where we saw that patients were always treated with dignity and their privacy and independence respected. Out of 50 hospitals, 41 (82%) were meeting the standards for respecting patients' privacy and dignity and involving them in decisions about their care. This compares with 88% of hospitals in the 2011 review. It is clearly unacceptable that this position, poor to begin with, has deteriorated further.

Overall we inspected the 50 hospitals against five standards: respecting and involving people, meeting their nutritional needs, safeguarding them from abuse, staffing, and records. We found that 33 hospitals were meeting all five standards. At the other end of the scale, three hospitals were meeting just two of the five standards, one hospital was meeting only one and one was not meeting any.

Of the nine hospitals we inspected in both 2011 and 2012, seven had either improved or were continuing to meet the standards. For the other two hospitals, we identified concerns in staffing levels in one and record keeping in another.

What worked well

It is particularly disappointing that patients continue to receive poor care in some hospitals when our inspectors found many examples of hospitals that were providing good and excellent care in relation to patients' dignity and nutrition. This was confirmed by the positive comments we received from patients and their families.

All hospitals can and should learn from each other in terms of what works well. The following are some of the things highlighted by our inspectors. They are part of a **culture** of care that puts patients first:

- Staff documented patients' wishes and preferences, involving relatives where the patient did not have the capacity to give that information themselves. This information was updated and reviewed regularly.
- Patients were asked how they wanted to be addressed.
- Staff were familiar with patients' needs, and so could often anticipate their care requirements.
- Hospitals had some means of helping to make sure that patients' privacy was respected when bedside curtains were closed – for example by using 'do not enter' signs.
- Hospitals provided flexible catering, including offering choice in meals, their portion size, and when they could be ordered.

We also found that those hospitals providing good care had **systems** firmly in place to record and monitor patients' needs:

- Staff reviewed and adapted patients' care plans in line with their changing needs.
- Hospitals completed nutritional risk assessments when patients were admitted and reviewed these on an ongoing basis. Appropriate referrals were made to other health care professionals (for example, dietitians).
- Staff recorded patients' food intake and fluid balance accurately.
- Patients' weights were recorded and monitored if needed.

What needs to improve

Where CQC's inspectors did find problems, there were some common failings. Many of these issues arise from cultures of care that put tasks before people.

Respecting and involving people who use services

Forty-one of the 50 hospitals were meeting this standard. Where we found problems, they included:

- Staff not involving patients enough in care planning, or recording their preferences and dislikes.
- Staff discussing confidential patient information in a public area.
- Patients not having anywhere to lock away their personal belongings.
- Staff 'talking over' patients as though they were not there.
- Patients not always being able to reach call bells, or staff not responding to them in a reasonable time.

Meeting nutritional needs

Forty-four of the 50 hospitals were meeting this standard. Where we found problems, they included:

- Staff not giving patients the help they need to eat and drink, or accurately recording what they eat and drink.
- Hospitals not always giving patients a suitable choice of menu.
- Delays in clinical referrals for nutrition or dietetic advice.
- Many patients not being given the opportunity to wash their hands before or after eating their meals.

Safeguarding people who use services from abuse

Forty-seven of the 50 hospitals were meeting this standard. Where we found problems, they included:

- Not all staff were knowledgeable and trained in safeguarding.
- Hospitals not having a formal system in place to learn from incidents.
- Some staff not being fully aware of the Mental Capacity Act 2005, or when Deprivation of Liberty Safeguards might apply.

Staffing

Forty-seven of the 50 hospitals were meeting this standard. Where we found problems, they included:

- Patients told our inspectors that they waited a long time before staff answered call bells. We saw that this was the case in some of our visits.
- Both staff and patients told us that there were not enough staff on duty to meet the needs of patients.
- In one hospital, staff not following the findings of patients' nutritional assessments.

Records

Thirty-four of the 50 hospitals were meeting this standard. Where we found problems, they included:

- Some hospitals not carrying out individual risk assessments.
- Staff failing to update nutritional assessments.
- Staff monitoring patients' food and fluid balance inaccurately.
- Hospitals not integrating their records system sufficiently, with paper and digital systems both being used.
- Staff not completing records (we saw, for example, incomplete do not attempt resuscitation (DNAR) records).

Conclusions and recommendations

Most of the hospitals we inspected were caring for people with dignity, treating them with respect, and supporting them to make sure their nutritional needs were met. Compared with our previous dignity and nutrition programme, more hospitals were meeting people's nutritional needs but fewer hospitals were meeting the standard on dignity and respect.

To make the improvements needed, the hospitals concerned must:

- Implement the best systems to ensure people's nutritional needs are identified and met. These needs should be reviewed, and any risks addressed, including making timely referrals for nutritional advice or treatment.
- Make sure that all staff understand safeguarding and their responsibilities in protecting patients from the risk of abuse. This should include an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Improve the standard of record keeping, with staff maintaining accurate, appropriate information to support patient care, for example ensuring that decisions not to resuscitate (DNAR) are accurately recorded in line with best practice.

Above all, those involved in planning, commissioning and delivering care should learn from what works well and increase their focus on ensuring people are treated with dignity and shown respect.

1. Introduction

In October 2011, we published our first report on 100 unannounced inspections of NHS trusts, where we specifically looked at standards of dignity and nutrition on NHS acute hospital wards caring for older people.¹ While we found examples of good and excellent care, we also reported that 20 hospitals were failing to meet the standards that the law says people should expect.

Between July and August 2012, we carried out a further review of dignity and nutrition standards for patients at 50 NHS hospitals. We inspected a combination of hospitals that raised concern during the original review and a new sample that included some NHS mental health trusts. The individual hospital reports from these inspections have already been published on our website. This national report summarises what we found.

Our published inspection reports on all 50 hospitals contain details of any actions they needed to take where they were not meeting the standards of quality and safety. We are following-up with these hospitals to ensure that these actions have been completed.

We have also carried out a programme of inspections looking at dignity and nutrition in 500 care homes for older people across England. We are publishing a national report on these inspections at the same time as this report.²

1 Care Quality Commission (CQC), *Dignity and nutrition inspection programme: National overview*, October 2011.

2 CQC, *Time to listen: In care homes – Dignity and nutrition inspection programme 2012: National overview*, March 2013.

2. How we carried out these inspections

The themed inspections ran between July and August 2012, focusing on dignity and nutrition for older patients in hospital. The programme ran alongside our ongoing inspections of hospitals in England.

Advisory Group

The programme was supported by an Advisory Group that provided advice and challenge throughout the inspection programme.

Membership of the Advisory Group can be found in appendix B.

The sample

We identified 50 NHS trust hospitals to be included in the programme from 223 trusts nationally. The sample was made up of hospitals from 37 acute trusts and 13 mental health trusts. For each of these trusts we inspected two service areas or wards caring for older people. We had inspected nine of these trusts as part of our previous dignity and nutrition programme, but this time we inspected different services or wards.

The number chosen from each of CQC's four regions (North, Central, London and South) was based on the proportional representation of each region within the national population. London has the smallest proportion of NHS trust hospitals nationally, therefore had the smallest number of locations within the sample group.

Table 1 below summarises the final allocation of inspections.

Table 1

| Region | Mental health trust | Trust followed up from previous programme | Other acute trusts | Total |
|--------------|---------------------|---|--------------------|-----------|
| North | 4 | 3 | 9 | 16 |
| Central | 4 | 4 | 6 | 14 |
| South | 3 | 1 | 8 | 12 |
| London | 2 | 1 | 5 | 8 |
| Total | 13 | 9 | 28 | 50 |

The standards

Each inspection looked at five of the national standards of quality and safety that are related to the theme of dignity and nutrition. These included two key standards: respecting and involving people who use services and meeting nutritional needs. The other standards were about safeguarding, staffing and record-keeping. For each standard, we identified two or three key areas (sub-themes) that the inspection teams looked at during the inspections, and which were used to describe our findings in the inspection reports (see box A).

Box A: The standards and sub-themes reviewed in the dignity and nutrition themed inspections

Respecting and involving people who use services

- Are people's privacy and dignity respected?
- Are people involved in making choices and decisions about their care?

Meeting nutritional needs

- Are people given a choice of suitable food and drink to meet their nutritional needs?
- Are people's religious or cultural backgrounds respected?
- Are people supported to eat and drink sufficient amounts to meet their needs?

Safeguarding people who use services from abuse

- Are steps taken to prevent abuse?
- Do people know how to raise concerns?
- Are the Deprivation of Liberty Safeguards used appropriately?

Staffing

- Are there sufficient numbers of staff?
- Do staff have the appropriate skills, knowledge and experience?

Records

- Are accurate records of appropriate information kept?
- Are records stored securely?

The inspections

Themed inspections are one of three types of inspections we carry out. The others are planned inspections, which are part of our ongoing programme, and responsive inspections when we respond to a problem or concern. All of our inspections are carried out under the Health and Social Care Act 2008 which describes the regulations a registered provider must meet. Information on how CQC carries out its inspections and the national standards of quality and safety that it inspects against is included in appendix C.

As part of the planning for each inspection we reviewed all the information we held about each hospital and contacted relevant stakeholders, including local involvement networks.

Apart from one inspection, we carried out our visits on a single day, including a number of visits during the weekend. On each visit we visited at least two ward or unit areas, typically arriving at 9am and staying until 4pm, though at some locations the visit was staggered to allow us to observe breakfast or the evening meal.

Our inspection teams

The programme was a collaborative effort, working with 31 practising professionals (including geriatricians, nurses and dietitians) and 35 Experts by Experience (people with direct experience of care services). Each inspection was led by a CQC compliance inspector and, in most cases, was supported by a second CQC inspector.

Experts by Experience took an active part in the inspection and talked to patients and relatives using the service. They also looked at the environment, saw how staff and patients interacted and what the atmosphere felt like.

Tools

In the inspections, we used specifically developed observation, interview and record-tracking tools to help assess the quality of care given to older people with the focus on dignity and nutrition. We spent time on hospital wards and units that cared for older people, observing a meal time, and talking to patients, relatives and a variety of staff.

Many of the places we were inspecting were caring for, and treating, patients with dementia – either in mental health trust hospitals and units or in acute hospitals. Our inspectors used an observation tool, called the Short Observational Framework for Inspection 2, which is specifically designed to help capture the experiences of people who may not be able to express this for themselves.

3. Our findings

Overall levels of hospitals meeting the standards

We inspected 50 hospitals against five standards overall: respecting and involving people, meeting their nutritional needs, safeguarding them from abuse, staffing, and records. We found that:

- 33 hospitals were meeting all five standards.
- 5 were meeting four out of the five standards.
- 7 were meeting three out of the five standards.
- 3 were meeting just two of the five standards.
- 1 hospital was only meeting one of the five standards.
- 1 hospital was not meeting any of the five standards.
- 41 of the 50 hospitals were meeting the standard about respecting and involving patients who use services.
- 44 of the 50 hospitals were meeting the standard about meeting nutritional needs.
- 47 of the 50 hospitals were meeting the standard about safeguarding.
- 47 of the 50 hospitals were meeting the standard about staffing.
- 34 of the 50 hospitals were meeting the standard about records.

Of the nine hospitals we inspected in both 2011 and 2012, seven had either improved or were continuing to meet the standards. For the other two hospitals, we identified concerns in staffing levels in one and record keeping in another.

Overall, we found that mental health trusts performed slightly better than the acute trusts in all but one of the five standards inspected.

You can find detailed figures comparing performance against the standards between, for example, trust types and regions in appendix A

Respecting and involving people who use services

Forty-one of the 50 hospitals were meeting the standard about respecting and involving patients who use services. For this inspection programme, we checked this standard under two subheadings – ‘Are patients’ privacy and dignity respected?’ and ‘Are patients involved in making decisions about their care and treatment?’.

Are patients’ privacy and dignity respected?

What worked well

In the hospitals meeting the standard we saw the following examples, which reflected care that respected patients’ privacy and dignity:

- Ward staff were trained in dementia care and understood issues of mental capacity.
- The hospital had some means of helping to make sure that patients’ privacy was respected when bedside curtains were closed – for example, ‘do not enter’ signs, or staff carrying a clothes peg in their pocket to keep privacy curtains together.
- Separate toilets and bathrooms for men and women.

Comments from patients at hospitals meeting this standard included, “It’s fine. They go out of their way to be helpful. Staff showed me my call bell and they are always available.”

What needs to improve

Of the nine hospitals not meeting the overall standard on respect and involvement, eight were failing to respect people’s privacy and dignity. The key themes we saw in hospitals not meeting this part of the standard were:

- Staff making thoughtless comments that showed a lack of respect for the people in their care.
- Staff discussing confidential patient information in a public area.
- Patients not having anywhere to lock away their personal belongings.
- Staff talking over patients as though they were not there.
- Patients not always being able to reach call bells, or staff not responding to them in a reasonable time.

Extracts from inspection reports

“For example, they [member of staff] stood directly behind a patient and leant over them to cut up their food. They also called across to a colleague who was supporting a patient with eating, ‘I think you’ve got a lost cause there’, referring to the fact that the patient was falling asleep during the meal.”

“We overheard staff speaking by telephone in the corridor at a nurse’s station about patients’ needs.”

“We looked at care plans and found that the staff referred to the person as ‘the patient’ and not by their name.”

“One person commented that a member of night staff had displayed annoyance when they had drawn their attention to a patient who was calling for assistance. They said that the member of night staff had told them not to interfere. They told us that this had made them feel frightened to call for help at night.”

“We noted that on Ward A many people did not have their nurse call bells within reach. We observed that when patients did use their nurse call bells, there was a 45 minute delay before the patient was attended which meant that the patient was not able to drink their cup of tea while it was still hot.”

“Staff made efforts to maintain patients’ dignity by using gowns and drawing the curtains when providing personal care. However, on both wards we saw that some curtains did not always close and this did not afford people full privacy.”

“We also noticed that some patients could not reach their drink; this meant that some patients had to wait for long periods for a drink.”

Are patients involved in making decisions about their care and treatment?

What worked well

In the hospitals meeting this standard we saw the following examples of patients being involved in their care and treatment:

- Patients were asked how they wished to be addressed.
- Patients’ wishes and preferences were documented, involving relatives where the patient did not have the capacity to convey that information themselves. This information was updated and reviewed regularly.
- Care plans were reviewed and adapted in line with patients’ changing needs.

Comments from patients at hospitals meeting this standard included, “The doctor has been today and has explained everything to me.”

What needs to improve

Of the nine hospitals not meeting the overall standard on respect and involvement, six were failing to involve people in choices and decisions about their care and not documenting their preferences or dislikes.

Extracts from inspection reports

“Staff we spoke with were not aware of patients’ individual religious needs. We spoke with one patient who told us that despite their strong beliefs and visits from their vicar on previous stays in the hospital, on this occasion no one had asked them about their faith and they were unaware of the services available at the hospital.”

“We did not see many people being given the opportunity to be actively engaged in their care although staff that we spoke with told us they did seek the views and preferences of people they cared for. Staff said when a person was unable to communicate their needs they checked what was recorded in their care plan or referred to the person’s family or carers. We found that this did not always happen in practice.”

Meeting people’s nutritional needs

Forty-four of the 50 hospitals were meeting the standard about respecting and involving patients who use services. For this inspection programme, we checked this standard under three subheadings – ‘Are patients given a choice of suitable food and drink to meet their nutritional needs?’, ‘Are patients’ religious and cultural backgrounds respected?’, and ‘Are patients supported to eat and drink sufficient amounts to meet their needs?’.

Are patients given a choice of suitable food and drink to meet their nutritional needs?

What worked well

In the hospitals meeting this standard we saw the following examples of the choice that patients had in what they ate and drank:

- Menus offered a choice of suitable meals to meet all patients’ needs, including control over portion size and promotion of healthy eating options.
- Patients were able to order food and drink throughout the day.
- The hospital provided food and drink (such as snack boxes) for patients who had to miss a meal to attend an appointment.
- In some dementia care units, meal options were plated up and shown to the patients to help them make their choices.

Comments from patients at hospitals meeting this standard included, “Food choice is tremendous. At other hospitals I’ve been in, they ask you what you want the day before. But here they ask you what you’d like for tea just before you eat. It’s much better as you can just choose what you fancy.”

What needs to improve

Of the six hospitals not meeting the overall standard on meeting nutritional needs, two were failing to give patients a choice of suitable food and drink, in the ways shown in the report extracts below.

Extracts from inspection reports

“One patient told us they had pureed food and felt that the portions were too big as they were unable to eat more than a few spoonfuls. They said that staff, ‘Can’t understand I can’t take it, they keep bringing it’. We observed at lunchtime that this patient was served a large portion and refused their meal after trying a small amount. We saw that the patient was quite frustrated by being given portions they could not eat.”

“They [patient] were then offered a cheese sandwich. However, they were given chips with salad and a chunk of cheese which they did not eat. Staff did not give them a reason why they could not have the sandwich they had chosen and no further main meal choices were offered when they did not eat their meal.”

Are patients’ religious and cultural backgrounds respected?

What worked well

In the hospitals we inspected it was generally commonplace for the menu to be varied and include options for patients who required a choice of diet in accordance with their religious or cultural needs.

What needs to improve

We found only one hospital that failed to meet this part of the standard, with the inspector reporting, “As information on patients’ religious and cultural needs were not recorded, those patients who were unable to make their preferences known may not have received food and drink that met their individual needs.”

Are patients supported to eat and drink sufficient amounts to meet their needs?

What worked well

In the hospitals meeting this standard we saw the following examples of patients being supported:

- Protected mealtimes, so that patients were not interrupted.
- Systems for identifying patients with particular nutritional needs – for example, using red trays to identify patients who need additional help to eat and drink.

- Nutritional risk assessments completed on admission and reviewed on an ongoing basis.
- Referrals made to dietitians and speech and language therapists.
- Where appropriate, the completion of accurate food intake and fluid balance records.
- Enough staff on duty to ensure that all patients received the support they needed to eat and drink.

Comments from patients meeting this standard included, “They are very concerned here about you drinking enough.”

What needs to improve

Of the six hospitals not meeting the overall standard on meeting nutritional needs, five were failing to provide adequate support for patients to eat and drink sufficient amounts for their needs. All but one hospital was using a nutritional risk assessment tool to identify those patients at risk of malnutrition. However, the fact that 10% of hospitals were failing to meet this aspect of the standard is chiefly explained by staff not properly using these tools, or generally not being aware of the basic support needs of patients. This is reflected in the extracts below.

Extracts from inspection reports

“Another person who was in need of some support to eat was given some assistance by staff to start her meal. This support was abandoned after a couple of minutes and her ability to help herself quickly deteriorated as she tried to use a knife as a spoon with little effect.”

“We saw that some patients did not receive appropriate support and encouragement. For example, staff woke one patient when they took the patient’s lunch to them. The patient went back to sleep and the meal remained in front of them until they woke up.”

“On the stroke ward staff concentrated on delivering the food in a timely manner, but patients were not always positioned in a way that helped them to eat without assistance. For example food was left for a patient who was lying in bed by the bedside table. The person was slumped in bed and the table was not near the person. They had to call for assistance. We observed a care assistant remove a tray without asking if the patient had finished.”

“The food charts were not always completed for evening meals and had not been reviewed to ensure that people’s nutritional needs were regularly updated. This meant that there was insufficient evidence to inform clinical decisions about treatments and interventions in order to ensure people were protected from inadequate nutrition and hydration.”

“Two patient records we looked at had identified clinical nutritional interventions. However, in one instance the procedure had not been completed. The patient had not received a Malnutrition Universal Screening Tool assessment and therefore had not been referred for a dietetic review.”



Safeguarding people who use services from abuse

For these inspections, we checked what steps are taken to prevent abuse, whether people know how to raise concerns, and whether staff use the Deprivation of Liberty Safeguards appropriately.

What worked well

Forty-seven of the 50 hospitals were meeting the standard about safeguarding. Here, we saw the following examples, which reflected that patients were safeguarded from the risk of abuse:

- Staff had received training in the trust's safeguarding policies and procedures. They were confident in being able to recognise the potential types of abuse and were able to describe how they would report them.
- The trust had a safeguarding lead in post.
- Patients and their relatives knew how to raise a concern about their care.
- The trust had a whistleblowing policy and procedure and staff could show use how they would use it.
- Staff understood mental capacity.

What needs to improve

In the three hospitals that were not meeting the standard about safeguarding, the key themes we saw were:

- Not all staff knew about or had received training in safeguarding.
- There was no formal system in place to learn from incidents.
- Some staff were not fully aware of the Mental Capacity Act 2005 or when Deprivation of Liberty Safeguards might apply.

Extracts from inspection reports

“The staff we spoke with did not recognise that meeting people’s needs could reduce the potential for abuse. We found evidence that not all patients had received appropriate assessments of physical and mental needs. This omission means that patients were not always safeguarded from the risk of abuse.”

“Staff did not demonstrate an understanding of the need to report safeguarding incidents to the local authority safeguarding team, although the safeguarding policy for the trust did direct staff to do this.”

“We asked the ward sisters what the staff had learnt from these incidents; they told us the information about incidents were not available to staff. There was no evidence that there had been learning from these incidents.”

“We spoke with staff who were uncertain when capacity assessments would be necessary or how a person’s liberty may be deprived.”

“Staff were not sure who was responsible for establishing whether a patient had mental capacity.”

Staffing

For these inspections, we checked whether hospitals had sufficient numbers of staff, and if staff had the appropriate skills, knowledge and experience.

What worked well

Forty-seven out of 50 hospitals were meeting the standard about staffing. Here, we saw the following examples, which reflected that there were sufficient numbers of suitable skilled and experienced staff on duty.

- People were being helped or cared for when they needed it.
- Staff were answering call bells promptly.
- Hospitals had access to additional staff when required, often through banks or agencies.
- Staffing numbers were linked to the needs and dependencies of the patients.
- Staff were familiar with patients’ needs, and so could often anticipate their care requirements.
- Staff had carried out training specifically related to nutrition.

Comments from patients at hospitals meeting this standard included, “Although the unit is very busy, staff have always got time to talk and they seem to work as a team.”

What needs to improve

In the three hospitals that did not meet the standard on staffing, the key themes were:

- Patients saying that it took a long time to have their call bells answered. We also saw this during our visits.
- Both staff and patients told us that there was just not enough staff on duty to meet the needs of patients. This was often a problem because the hospitals could not replace staff who were absent due to staff sickness or other short-notice absence.
- Only one hospital was failing to ensure staff had the appropriate skills, knowledge and experience, and this was because staff did not have the right skills to use a nutritional screening tool properly and were not trained to manage patients with dementia.

Extracts from inspection reports

“Patients on both wards told us that staff took a long time to respond to call bells. Patients said that this caused them embarrassment and inconvenience as they had to wait long periods to be supported to go to the toilet or eat their meals.”

“We saw patients waiting for long periods to be sat up to have a drink. One nurse explained that due to the high dependency levels on the ward they were not able to get round to everyone, although they did say that they would be able to respond if there was an emergency.”

“All staff told us they considered that staffing levels were inadequate to meet the needs of patients on the ward.”

“We spoke with staff who said they had received training from the dietitian on how to complete the nutritional assessment tool. However, the nursing staff were not completing or following the instructions on the nutritional screening and assessment tool. This meant that people were not being identified as being at risk of poor nutrition or hydration.”

“We observed that staff were busy and did not notice that the call bells and drinks were not within reach or that some patients were uncomfortable. The staff we spoke with told us they were very busy and had not been trained in looking after patients with dementia.”

Records

For these inspections, we checked whether hospitals kept accurate records of appropriate information, and whether these records were stored securely.

What worked well

Thirty-four of the 50 hospitals were meeting the standard about records. Here, we saw the following examples, which reflected that records were both accurate and fit for purpose, and were securely and confidentially stored.

- Multi-disciplinary records showed that patients had their nutritional risk assessed on admission and then this was regularly reviewed. Appropriate referrals were made to other healthcare professionals (for example, dietitians).
- Patients' weights were recorded and monitored if needed.
- Records of patients' food intake and fluid balance were accurately completed.
- Working records, such as fluid balance charts, were kept near to the patient, with medical notes holding confidential information being held securely but within easy reach of staff.

What needs to improve

Sixteen hospitals were not meeting the standard on records, although we judged 14 of these as having a minor impact on patients' health, safety and welfare. The key themes we saw in these hospitals were:

- A lack of proper individualised risk assessments.
- Staff failing to update nutritional assessments.
- Inaccurate food and fluid balance monitoring.
- Staff using both paper and IT-based record systems.
- Staff failing to complete records. This was especially the case with 'do not attempt resuscitation' records.
- Only one hospital was failing to keep records secure, since patient information was not stored confidentially.

Extracts from inspection reports

“We reviewed the healthcare records of five patients on the ward. We found in four records that the patient’s fluid intake and output was not consistently recorded. For example, for one patient whose fluid intake and output were being monitored, we saw that over a period of six days the fluid balance chart had been completed on three days. Another patient’s records showed that fluid balance charts had been completed in detail on two days out of five. On two days the charts had been partially completed and on one day the chart had been left blank.”

“In another record we saw there was no documented evidence of why a patient remained nil by mouth for nine days and there was no audit trail to record the clinical decision process.”

“We reviewed ‘do not attempt resuscitation’ (DNAR) forms that we found in the healthcare records of 12 patients on the ward. We noted that four DNAR forms had been completed in full and this included a record of discussions with the patient or their relative about the decision. However, the other eight DNAR forms were incomplete. The eight forms either failed to record whether or not the patient had the ‘capacity’ to make the decision themselves or, where they did not have capacity, there was no record that a relative had been contacted or spoken with. This meant that two thirds of the forms did not record the necessary information in relation to the decision not to attempt resuscitation.”

“We observed that confidential and sensitive information was kept with patients’ names on a white board, which could be seen by members of the public. For example, we were able to ascertain which patients required assessments, including those for mental capacity, and which patients were catheterised.”

4. Follow up

Publication and follow up

We have published reports for each of the 50 hospitals inspected as part of this programme. They are available at: www.cqc.org.uk/DANI

Where a hospital was not meeting a standard, we judged what impact this was having on people using the service, and then asked the trust to send us a report setting out what they intend to do. When they have made the required improvements we check that the provider is meeting the standard. This will often involve a follow-up inspection, but can be done by reviewing information from the trust. If, on follow-up the standard is met, we update our website. If it's not, we consider our next actions using our enforcement policy as a guide.

Evaluation

We are currently evaluating our regulatory activity and will publish the findings later this year. This includes all of our different inspection methodologies and includes themed inspections. This work will help us identify the impact of our work and the best use of our resources.

Patient-Led Assessments of the Care Environment (PLACE)

On 6 January 2012, the Prime Minister announced that a new patient-led inspection regime would be introduced covering privacy and dignity, food and cleanliness in hospitals. The results of these inspections (which will replace the current Patient Environment Action Team (PEAT) inspections from April 2013) will be reported on publicly, to help drive up standards of care. The key feature will be the involvement of patients, or their representatives, at all stages, including development of the system, the inspection process and validation of inspections.

Following discussions with a number of organisations and consultations with patient representative organisations a proposed process and assessment – PLACE (Patient-Led Assessment of Care Environments) – has been developed by The Information Centre for health and social care. It is envisaged that the PLACE inspection programme will begin soon after April 2013. We will make sure that the findings from these inspections inform our assessments of risk and inspection programmes.

5. Conclusions and recommendations

Most of the hospitals we inspected were caring for people with dignity, treating them with respect, and supporting them to make sure their nutritional needs were met. Compared with our previous dignity and nutrition programme, more hospitals were meeting people's nutritional needs but fewer hospitals were meeting the standard on dignity and respect.

To make the improvements needed, the hospitals concerned must:

- Implement the best systems to ensure people's nutritional needs are identified and met. These needs should be reviewed, and any risks addressed, including making timely referrals for nutritional advice or treatment.
- Make sure that all staff understand safeguarding and their responsibilities in protecting patients from the risk of abuse. This should include an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Improve the standard of record keeping, with staff maintaining accurate, appropriate information to support patient care, for example ensuring that decisions not to resuscitate (DNAR) are accurately recorded in line with best practice.

Above all, those involved in planning, commissioning and delivering care should learn from what works well and increase their focus on ensuring people are treated with dignity and shown respect.

Appendix A: Tables of findings

Regional comparisons

Table 2 gives the breakdown of hospitals meeting the national standards by CQC region. All figures in the following tables are in proportion to the number of hospital locations in each region.

The North region had the highest level meeting three standards (nutritional needs, safeguarding and staffing), but the lowest level in meeting the standard relating to records.

Table 2: Performance by region (% meeting the standards)

| | Region, number of hospitals inspected, and % meeting the standards | | | |
|--|--|-------|--------|---------|
| | 16 | 12 | 8 | 14 |
| Standard | North | South | London | Central |
| Respecting and involving people who use services | 81.3% | 83.3% | 87.5% | 78.6% |
| Meeting nutritional needs | 93.8% | 91.7% | 87.5% | 78.6% |
| Safeguarding people who use services from abuse | 100% | 100% | 75% | 92.9% |
| Staffing | 100% | 100% | 87.5% | 85.7% |
| Records | 62.5% | 83.3% | 75% | 64.3% |

Comparison by trust type

Our sample of 50 trusts included 37 acute hospitals and 13 mental health hospitals. Table 3 shows the difference in levels of performance against the five inspected standards between acute and mental health trusts.

Acute trusts only outperformed mental health trusts in the standard concerning safeguarding. Performance was higher in mental health trusts for the other four standards inspected.

Table 3: Performance by trust type (% meeting the standards)

| Standard | Acute trusts (37) | Mental health trusts (13) |
|--|-------------------|---------------------------|
| Respecting and involving people who use services | 81.1% | 84.6% |
| Meeting nutritional needs | 86.5% | 92.3% |
| Safeguarding people who use services from abuse | 94.6% | 92.3% |
| Staffing | 91.9% | 100% |
| Records | 67.6% | 76.9% |

Dementia

Table 4 shows the levels of standards being met between hospital locations (wards/units) which either care for patients with dementia or do not and those who have a dedicated dementia unit or do not. The percentages in the table below are in proportion to the number of wards/units with or without dementia care.

- Locations that did not care for patients with dementia were more likely to meet all five standards than those which do care for patients with dementia. However, this is based on a relatively small number of locations which do not care for patients with dementia – only seven.
- Locations that did not have a dedicated dementia care ward or unit were more likely to meet the standard that relates to respecting and involving patients (84.8% to 76.5%) than those that did have a dedicated ward/unit.
- Locations that did not have a dedicated dementia care ward/unit were less likely to meet the standards relating to staffing and records than those which did have a dedicated dementia unit/ward.

Table 4: Performance by ward/unit type (% meeting the standards)

| | Number of locations | | | |
|--|---|--|---|--|
| | 43 | 7 | 17 | 23 |
| Standard | Wards/ units that DO care for patients with dementia | Wards/ units that DO NOT care for patients with dementia | There IS a dedicated dementia care unit/ ward | There IS NOT a dedicated dementia care unit/ ward |
| Respecting and involving people who use services | 81.4% | 85.7% | 76.5% | 84.8% |
| Meeting nutritional needs | 86.0% | 100% | 88.2% | 87.9% |
| Safeguarding people who use services from abuse | 93.0% | 100% | 94.1% | 93.9% |
| Staffing | 93.0% | 100% | 100% | 90.9% |
| Records | 65.1% | 85.7% | 70.6% | 66.7% |

Comparisons with the first programme of dignity and nutrition inspections for NHS hospitals

The following table shows the difference in performance between hospitals inspected as part of the first dignity and nutrition themed review (in 2011) and those inspected for the second one (in 2012). In the first programme, only the standards relating to respecting and involving patients and meeting nutritional needs were inspected, and therefore only these standards and their constituent sub-themes have been compared.³

³ When drawing direct comparisons between the first and second programmes, it should also be noted that some issues not directly related to the standards being inspected were used in making judgements. For example, for the first programme, when we reported on the standard dealing with meeting nutritional needs, we included information where notes did not accurately record patients' consumption of food and drink. In the second, we have broadened the scope of the standards we have looked at. So our inspectors checked issues about the accuracy of recording appropriate information when judging whether hospitals were meeting the standard about records.

Locations inspected in 2012 tended to perform worse against the standard concerning privacy and dignity than the 100 locations inspected during the first programme. On the other hand, hospitals inspected in the 2011 programme had lower levels of performance for the standard relating to meeting nutritional needs than those inspected as part of the 2012 programme. It should be noted that no mental health trusts were inspected as part of the first programme.

Table 5: Performance between the themed inspections in 2011 and 2012

| | Number of hospital locations | | |
|--|------------------------------|------------------------------|----------------------------------|
| | 100 | 50 | 37 |
| Standard (and sub-theme) | Results from 2011 | Results from 2012 all trusts | Results from 2012 – acute trusts |
| Respecting and involving people who use services | 88% | 82% | 81.1% |
| Privacy and dignity respected? | 91% | 84% | 83.8% |
| Involved in making choices and decisions about their care? | 85% | 88% | 86.5% |
| Meeting nutritional needs | 83% | 88% | 86.5% |
| Choice of suitable food and drink to meet individual needs | 77% | 96% | 97.3% |
| Respect of religious or cultural backgrounds | 82% | 98% | 97.3% |
| Supported to meet eating and drinking needs | 89% | 90% | 86.5% |

Common questions

As part of the programme, our inspection teams asked hospital staff four questions on each visit. The following table shows the responses to those common questions.

Table 6: Answers to our common questions in 2012

| Common questions | Answers at the 50 hospitals | |
|--|-----------------------------|-----|
| | Yes | No |
| 1. For every patient that you have pathway tracked were choices and decisions about their care documented? | 78% | 22% |
| 2. Was there a record of patients' individual food and drink preferences? | 78% | 22% |
| 3. Were any Deprivation of Liberty Safeguard authorisations in place for patients in the hospital? | 30% | 70% |
| 4. Did the trust use a formal tool (eg, Malnutrition Universal Screening Tool or MUST) to identify patients who were at risk of malnutrition | 98% | 2% |

1. For every patient that you have pathway tracked were choices and decisions about their care documented?

At locations where choices and decisions about care were documented (for everyone pathway tracked – ie, 39 locations), 92% were meeting the standard about respecting and involving patients. However, at locations where choices and decisions were not documented, more than half were not meeting the standard.

2. Was there a record of patient's individual food and drink preferences?

At locations where there was a record of patients' individual food and drink preferences (39 locations), 95% were meeting the standard about meeting nutritional needs. However at locations where there was no such record, only 64% were meeting the standard.

3. Were any Deprivation of Liberty Safeguard (DoLS) authorisations in place for patients in the hospital?

At locations where any DoLS authorisations were in place (15 locations), 93% of the hospital locations inspected were meeting all the standards. But at locations where there were no DoLS authorisations in place, only 54% were meeting all the five standards inspected.

4. Did the trust use a formal tool (eg, Malnutrition Universal Screening Tool or MUST) to identify patients who were at risk of malnutrition

All but one location used a nutritional risk assessment tool (such as MUST), so comparisons between those that do and don't use it are not really meaningful. This question just asked whether the trust used a nutritional risk assessment. This risk assessment was usually carried out on admission to the ward or unit. The 98% compliance rate with this question did not relate to the number of trusts that continued to review the nutritional risk on an ongoing basis.

Appendix B: Advisory Group

This themed inspection programme had the support of an Advisory Group to:

- Provide expertise and experience to inform the approach and scope of the programme.
- Comment and advise on the nature of the inspections in terms of focus (what should we be looking at) and desired outcomes.
- Advise on the presentation of results from the inspection programme.
- Consider what actions need to be taken by the wider system, and what the role of group members is in taking these forward.

CQC is grateful for the time, support, advice and expertise given by the group.

The group has no decision making authority regarding CQC's regulatory activity.

As well as members of CQC staff, the group comprised:

- Daniel Blake, POhWER (independent advocacy agency)
- Frances Blunden, NHS Confederation
- Ailsa Brotherton, BAPEN (British Association for Parenteral and Enteral Nutrition)
- Elaine Cass, Social Care Institute for Excellence
- Gary Fitzgerald, Action on Elder Abuse
- Clare Gorman, NHS Confederation
- Margot Gosney, Royal College of Physicians
- Anita Higham, Local involvement network representatives
- Elaine Jennings, British Dietetic Association
- Nicola Matthews, Kissing It Better
- Christine McKenzie, Royal College of Nursing
- Mary Milne, Age UK
- Kieran Mullen, Patients Association
- Jennifer Oates, Nursing and Midwifery Council
- Gerry Zarb, Equality and Human Rights Commission

Appendix C: How CQC checks whether national standards are being met

The Health and Social Care Act 2008 introduced for the first time a common set of standards – the essential standards of quality and safety – that apply across all regulated health care and adult social care services in England. Working to this new regime, CQC registered all NHS trusts and hospitals from April 2010 and independent healthcare and social care providers from October 2010 under the new regulation.

Once providers are registered, CQC inspectors check that the essential standards of quality and safety are being met. There are 28 standards in total but, of these, they focus on 16 standards that most directly relate to the quality and safety of care. CQC produces guidance for providers that helps them understand what meeting the essential standards looks like. The guidance sets out the outcomes that a person using the service can expect to experience if the provider is meeting the essential standards – with each essential standard having a corresponding outcome.

Providers must comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect.

As part of this themed inspection programme we inspected against the following regulations:

- **Regulation 17 Respecting and involving people who use services** (Outcome 1)
- **Regulation 14 Meeting nutritional needs** (Outcome 5)
- **Regulation 11 Safeguarding people who use services from abuse** (Outcome 7)
- **Regulation 22 Staffing** (Outcome 13)
- **Regulation 20 Records** (Outcome 21)

If an inspector identified concerns relating to another outcome they would include the additional regulation as necessary.

All judgements are made using CQC's judgement framework. We will judge whether a provider is either meeting or not meeting the regulations. Where we judge that a provider is not meeting a regulation, we assess the impact of this on

people who use the service, and judge it to be either minor, moderate or major. The level of impact determines the regulatory action we take.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant impact on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long-term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

As part of our consideration of impact, we also take into account who is using the service and what their circumstances are, as these factors may result in a greater impact. If we reach a judgement that the provider is not meeting one or more of the regulations, we use the Enforcement policy to help determine our regulatory response.

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