Care Quality Commission

Dignity and nutrition for older people

Review of compliance

Basingstoke & North Hampshire NHS Foundation Trust **Basingstoke & North Hampshire Hospital**	
Region:	South East
Location address:	Basingstoke & North Hampshire Hospital Aldermaston Road Basingstoke Hampshire RG24 9NA
Type of service:	Acute services
Publication date	July 2011
Overview of the service:	Basingstoke & North Hampshire NHS Foundation Trust was created on 1st December 2006. Basingstoke & North Hampshire Hospital is the sole location registered for the trust. It is a

	general acute hospital that provides a full range of adult, paediatric and maternity clinical specialties. The hospital serves a population of around 300,000 patients and has 450 beds. It is currently registered without conditions.

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

What we found overall

We found that Basingstoke & North Hampshire Hospital was meeting both of the essential standards of quality and safety we reviewed.

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

Why we carried out this review

This review 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 and carried out a visit on 16 May 2011 to ward F1 – Oakley Unit (Stroke rehabilitation) and ward F2 – Elderly care ward. We 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 spoke to eight members of staff and eight patients.

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

What people told us

The majority of patients we spoke to said that their experience had been positive; staff were polite, sensitive to their needs and treated them with respect. They were satisfied with their overall care.

Patients told us that the staff asked what name they liked to be called when they arrived on the ward and this was respected throughout their stay. Most patients told us the staff were very responsive to their needs and said that call bells were generally answered quickly. Two patients said there had been times when staff had been slow to respond to the call bell.

The majority of patients we spoke to said that staff explained to them what they were going to do prior to carrying out any personal care or treatment, for example, washing, assisting with toileting and taking blood.

All of the patients we spoke to said that they had been given enough information about their care and treatment. Some of the patients said that they had asked for their relatives to be given information about their care and treatment and the staff had spoken with their family members and answered their questions.

The majority of patients we spoke to said they had a good choice of food in sufficient quantities, regular hot drinks provided and cold water always available.

All of the patients we spoke to during the visit confirmed that the staff checked if they had enough to eat and drink and most patients knew that the staff completed a nutrition intake chart to monitor their intake of food and drink. Some patients stated that the food was sometimes not hot. Most patients said that if they did not like their meal or if they were hungry outside of mealtimes the staff would bring them a snack.

What we found about the standards we reviewed and how well Basingstoke & North Hampshire 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 Basingstoke & North Hampshire Hospital was meeting this essential standard.

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

- Overall, we found that Basingstoke & North Hampshire Hospital was meeting this essential standard.

Action we have asked the service to take

We have not asked the provider to take any action as a result of this report.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with outcome 1: Respecting and involving people who use services.

Our findings

What people who use the service experienced and told us

The majority of patients we spoke to said that their experience had been positive; staff were polite, sensitive to their needs and treated them with respect. They were satisfied with their overall care.

Patients told us that the staff asked what name they liked to be called when they arrived on the ward and this was respected throughout their stay. Most patients told us the staff were very responsive to their needs and said that call bells were generally answered quickly. Two patients said there had been times when staff had been slow to respond to the call bell.

The majority of patients we spoke to said that staff explained to them what they were going to do prior to carrying out any personal care or treatment, for example, washing, assisting with toileting and taking blood.

All of the patients we spoke to said that they had been given enough information about their care and treatment. Some of the patients said that they had asked for their relatives to be given information about their care and treatment and the staff had spoken with their family members and answered their questions.

Other evidence

The Patient Environment Action Team (PEAT – an annual assessment of inpatient healthcare sites) data for 2010 rated Basingstoke & North Hampshire NHS Foundation Trust as “Good” for dignity and respect.

Staff told us that they encouraged patient involvement in their care, for example, by ensuring that people maintained their independence as much as possible with washing and dressing. On one ward we saw physiotherapists and occupational therapists working with people to improve their independence.

We saw that curtains were drawn around individual beds whilst care was being delivered and signs were attached to the curtains advising people not to enter, which were respected. We saw that staff used the patients’ names when talking to them. All patients were accommodated in single sex bays or single rooms. There were designated male and female toilets. One ward we visited had designated male and female shower rooms. During the visit we saw that each bed space had a locker for patients’ personal belongings.

The trust had a procedure on patient privacy and dignity and the staff we spoke to said that they had received privacy and dignity training. The trust records we saw documented a range of ways of monitoring whether people who use the service were involved and respected. These included patient experience surveys, ward surveys, privacy and dignity audits and monthly nursing audits of standards of care. The patient experience survey results we saw for April 2011 showed that 85.9% of patients, who responded, said they had enough privacy when discussing their condition or treatment. Over 87 % of patients who responded to the survey said that they had been involved in decisions about their treatment or care.

On the wards we visited we observed that call bells were not always within easy reach for the patient. The call bells were very small and not easy for everyone to use. The staff we spoke to said that they were aware of the issue with the style of the call bells and were investigating how to improve them. We saw that some patients had been given a hand-held manual bell instead. Staff explained that patients were assessed with regard to their ability to use the call bell and when there were concerns that a patient may not be able to operate it, the patient was given a hand held bell.

The patient records we saw included detailed information regarding their personal choices or preferences using a form called “Get to know me”. The form was completed by the patient or relative on their behalf.

We could not find mental capacity assessments in the patient records we looked at. The staff we spoke to said that if there were concerns regarding a patient's capacity to make decisions regarding their care and treatment then medical staff would carry out a mental state examination. We did see records of mental state examinations in patients' notes. We also saw evidence of carer or next-of-kin involvement including forms completed by patients' next of kin where the patient was unable to complete or sign.

Senior ward staff we spoke to demonstrated an in-depth understanding of capacity considerations and best interest decisions. They gave us examples of when they had requested that Independent Mental Capacity Advocates represent patients. This service provides advocacy for people who cannot make independent decisions about medical treatment or residential care. Not all staff members we spoke to demonstrated the same level of understanding of capacity considerations. The trust provided us with information regarding their staff training which showed that basic mental capacity act training was provided to all staff on the trust induction programme. There was also a programme in place to provide all staff on the elderly care wards with additional mental capacity act training. We saw that there were patient information leaflets available and information posters in the wards but not all of these were accessible in different formats.

The staff we spoke to during the visit said that they gained feedback from the patients by talking to them, from the patient feedback forms on each ward. Staff told us that they also got feedback by talking to relatives and/or their carers, where appropriate. They gave us examples of changes to the care provided as a result of patient feedback including changes to the communication processes with relatives.

Our judgement

Most patients have their privacy, dignity and independence respected at Basingstoke & North Hampshire Hospital. Patients are given information about their care and treatment. Most patients are involved in their care and supported to maintain their independence as far as possible. Mental capacity assessments are carried out when there are concerns about a patient's capacity to make decisions.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

The majority of patients we spoke to said they had a good choice of food in sufficient quantities, regular hot drinks provided and cold water always available.

All of the patients we spoke to during the visit confirmed that the staff checked if they had enough to eat and drink and most patients knew that the staff completed a nutrition intake chart to monitor their intake of food and drink. Some patients stated that the food was sometimes not hot. Most patients said that if they did not like their meal or if they were hungry outside of mealtimes the staff would bring them a snack.

Other evidence

The Patient Environment Action Team (PEAT) data for 2010 rated Basingstoke & North Hampshire NHS Foundation Trust as “Good” for food. The trust rated much worse than expected in the PEAT data for 2010 for the proportion of wards that operated a protected mealtime policy. The trust provided us with a copy of their protected mealtime observational audit for 2010. The audit concluded that the wards were providing an environment which encouraged patients to eat and assistance was provided to patients that required it. The audit also concluded that not all wards displayed the protected mealtimes poster and staff did not make sure

that patients were ready to eat. The trust provided evidence that the results of the audit had been fed back to their nutrition steering group and that protected mealtime awareness had been incorporated into new medical staff's induction training from July 2010. Protected mealtimes were featured in the nutrition week held at the trust in September 2010.

We observed that the wards we visited operated a protected mealtime policy. There were signs in the wards explaining the policy and we saw that the wards were quieter during the lunchtime meal.

We saw that patients who either needed assistance with drinking or were at risk of poor hydration had red jugs of water at their bedside. This was to identify them as patients who needed help from staff. We observed staff assist patients with taking drinks and encourage patients to drink more. We also saw that staff recorded the amount of fluids patients were drinking in their fluid intake record.

We observed staff offer assistance to patients who needed help and support at mealtime. Staff opened the individual drink cartons for those who could not do so, they supported patients to sit up, offered to assist cutting meat and supported those patients to eat who could not do so unassisted.

Many staff members we spoke to said that it was sometimes a struggle to assist all patients who needed support at mealtimes. Some patients therefore had to wait to be assisted to eat and drink. Some staff members stated that they needed more dedicated staff or volunteers at mealtimes to support patients. Concerns have also been raised by relatives

There were information posters in the wards referring to the fortified meal and drink policy on both wards. Fortified milk was automatically given to patients on the wards and soup, porridge and milk puddings were also fortified. All patients were given a high protein menu without the need for individual requests from dietitians. The staff we spoke to said that they felt it had been a big improvement for patient care to have fortified milk and supplements automatically given to patients on these two wards.

We saw in patients' records that patients' dietary needs were recorded and there were individual stickers attached to people's notes and menu cards to indicate, for example, that they required a diabetic meal or vegetarian meal. The patient records we checked had completed fluid and meal intake records.

We found that not all patients had a completed malnutrition screening record in their patient notes. The trust's re-audit of the malnutrition universal screening tool (MUST) reported in 2010 found that 55% of patients had the malnutrition screening record completed during their admission against a target of 100% of inpatients. This screening tool is a five step process to identify adults who are either malnourished or at risk of being malnourished.

The trust's senior managers stated that they were taking action to improve the consistency of recording malnutrition screening. We saw the trust's MUST improvement action plan which indicated that the dietetic manager was working with matrons to review monthly spot check audits, identify relevant actions and to deliver

a nutrition training programme. These improvements were planned to be in place by 31 August 2011. We saw in patients' notes that dietitians and speech and language therapists (to assess swallowing issues) had been involved in the assessment and care of some patients.

We saw on both wards that the housekeeper spoke to every patient about their choice of meal from the menu in the morning. The housekeeper explained the meals to patients where necessary and discussed with them their food preferences in order to assist them in choosing their meals. During the visit we saw that the menu cards given to patients had very small type and many patients needed assistance to read them. The trust advised that their dietetic manager planned to develop a pictorial menu by 31 August 2011.

We observed that most patients at lunchtime were automatically given a napkin which was tied around their neck without checking with them first if they wished to have the napkin on their lap or around their neck. The senior staff we spoke to at the trust confirmed that they would speak to ward staff to ensure that patients were given a choice regarding napkin use.

On one ward we saw that four meals were missing from the meal trolleys at lunchtime; these were for four patients who were newly admitted or transferred to the ward. The housekeeping staff noticed the missing meals immediately because they counted the meals as they gave them out and recorded them on their checklists. One member of staff spoke to each person whose meal was missing, apologised that it would be late and assured them they had contacted the kitchen to send the missing meals. All four patients received meals but three were over forty minutes late. None of the patients affected appeared distressed or upset by the delay.

Our judgement

Most patients are helped and supported to receive adequate nutrition and hydration at Basingstoke & North Hampshire Hospital. Staff are aware of the need to provide assistance to patients to eat and drink. Food and fluid intake is recorded.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA