

Report to: **East Sussex Health Overview and Scrutiny Committee (HOSC)**

Date: **21 March 2013**

By: **Assistant Chief Executive**

Title of report: **Dignity in Care**

Purpose of report: **To consider the approach of local Trusts to ensuring dignity in care, with a focus on nursing care for older people.**

RECOMMENDATIONS

HOSC is recommended:

- 1. To consider and comment on the reports from Brighton and Sussex University Hospitals NHS Trust and East Sussex Healthcare NHS Trust (appendices 1 and 2).**
 - 2. To consider whether the Committee requires further reports on this issue.**
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1. Background

1.1 In 2009 HOSC agreed to review nutrition and hydration in local hospitals as it had been highlighted as an area for improvement nationally through campaigns such as the Dignity in Care programme and Age Concern's 'Hungry to be Heard' work. The review, which reported to the Committee in September 2010, focused on Brighton and Sussex University Hospitals NHS Trust (BSUH) and East Sussex Healthcare NHS Trust (EHST) as the two main acute provider Trusts for East Sussex residents.

1.2 HOSC made 10 recommendations for improvement, which were accepted by both Trusts in their initial responses to the Committee in November 2010. HOSC received progress reports on the implementation of these recommendations in June 2011 and March 2012. The Committee noted that significant progress had been made by both Trusts in areas such as use of malnutrition screening and provision of assistance with eating and drinking to patients, but there remained a need for ongoing focus in this area to ensure consistent levels of care for all patients all of the time.

1.3 Discussion of the last progress reports in March 2012 broadened out into more general issues of nursing care for older people, in particular the use of regular nursing rounds to ensure a range of patient needs are met including, but not limited to, nutrition and hydration. For this reason, HOSC requested a further report from each Trust on their overall approach to ensuring Dignity in Care, to incorporate a general update on progress with regard to nutrition and hydration.

1.4 This broader consideration of dignity issues fits with the approach taken by the Care Quality Commission to reviewing 'dignity and nutrition', and the national Dignity in Care campaign where the provision of appropriate nutrition and hydration are seen as part of the wider provision of dignified care for older people. Dignity in care factors include personal hygiene, privacy, choice and control, pain management and communication, as well as nutritional care. Further information is available at <http://www.dignityincare.org.uk> where individuals can also sign up as 'dignity champions'.

2. Trust reports

2.1 The report provided by BSUH is attached at appendix 1. The following representatives will attend to discuss the Trust's approach with HOSC:

- Ann Gibbins, Head of Nursing for Older People
- Joy Churcher, Head of Dietetics

2.2 The report provided by ESHT is attached at appendix 2. The following representatives will attend to discuss the Trust's approach with HOSC:

- Alice Webster, Director of Nursing
- Michelle Clements, Facilities Manager
- Lesley Houston, Dietetics Manager

SIMON HUGHES

Assistant Chief Executive, Governance and Community Services

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Dignity in Care – Brighton & Sussex University Hospitals NHS Trust

Introduction

Brighton & Sussex University Hospitals NHS Trust (BSUH) is committed to delivering the highest standards of care to every patient across its hospital sites. Reports such as Defending Dignity (2008 RCN), Care of Older People (2009 NMC), Patients not numbers, Patients not Statistics (2009 Patients Association) and Counting the Cost: Caring for Older People with Dementia on hospital wards (2009 Alzheimer's Society), have been instrumental in shaping the care we strive to deliver.

The Parliamentary and Health Service Ombudsman report (2011) 'Care and Compassion?' highlighted many failures in the care of Older People. More recently, the Commission for Improving Dignity in Care was established as part of a joint initiative from the NHS Confederation, Age UK and Local Government Associations to help improve Dignity in Care in Care Homes and for Older People in hospitals. Their report 'Delivering Dignity' (2012) highlights expertise from right across the care system, including nursing, social care, medicine and commissioning, as well as insights from representatives of service users.

In February this year, The Francis Report (2013) highlighted many failings at the Mid Staffordshire NHS Foundation Trust, which contributed to very poor patient care and experience and in some cases patient deaths. In considering the reports findings, the senior nurse team at BSUH have re-reviewed the care, standards and processes in place to ensure we deliver the highest standard of care across the Trust.

There are a number of initiatives taking place across the Trust to ensure the dignity of our patients continues to have the highest profile and to regularly assess that this is the case.

Clinical Engagement to support Dignity in Care

The Chief Nurse leads by example in terms of this commitment, ensuring all senior nurses on one morning every week (Wednesday) work clinically in addition to any other clinical work they may be committed to. This is protected time for the senior nursing team and no other commitments are booked in on this morning. This clinical work may be undertaken within the clinical wards or units the senior nurses are directly responsible for or in areas where they are less familiar. This has a

twofold benefit; within their own areas of responsibility, it assures the senior nurses the care being delivered is of a high standard and that this is a constant and sustained level of care; where they may choose to work in a clinical area outside of their responsibility, it supports providing a peer review of care using a 'fresh eyes' approach. This model allows the senior nursing team, who meet together once every week, a regular opportunity to share and challenge aspects of care they feel may have fallen below the high standards demanded from our Chief Nurse. This model also facilitates the senior nursing team to hear first hand from patients what they think of their care whilst delivering personal care themselves.

In addition, the Chief Executive and members of the board regularly visit the wards/units to see for themselves the care being delivered. This is especially so within the Care of the Older Peoples wards where the Head of Nursing actively encourages and facilitates these visits. These occur at varying times of the day so that the executive team have the opportunity to see care being delivered at different times of the day, but also to hear patient and carers views of the care being delivered or any other concerns patients or carers may have. It has also paved the way for members of the board or executive team, to go and visit the wards unescorted at any time they wish to, to see the care being delivered. The Chair of the Board is particularly keen to undertake this type of visit.

The Head of Nursing for Older People (a new appointment in the last 18 months) also actively encourages reviews and visits from outside the Trust such as the Patients Association, Local GP's, Leads in the DoH, members of the local PCT and CCG.

Nursing Care to support Dignity in Care

Two years ago the nursing team at BSUH adopted 'Comfort Rounds' into their every day practice. We designed and introduced 'Comfort Rounds' across the hospital; a two-hourly, rolling schedule of checks focused on the essentials of good nursing care: whether patients are clean, comfortable, have sufficient pain relief, whether they need a drink, to go to the bathroom, help to eat or change position to reduce the risk of pressure damage. Part of the senior nurses' responsibilities when working clinically, is to check these rounds are being undertaken and to take part in them themselves. Both trained and untrained nurses carry out these rounds ensuring that all staff understand the importance of trying to anticipate patients needs before they need to ring the bell; thus ensuring we are keeping them as comfortable as possible and negating any delay with regard to their care.

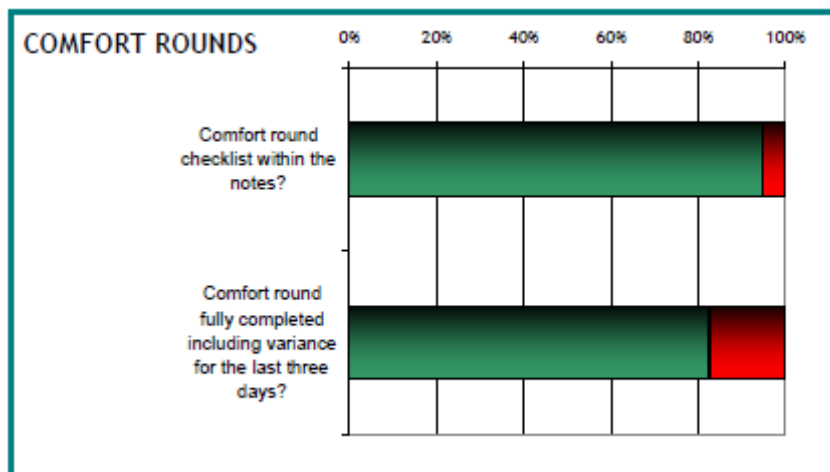
One of the ways in which we audit how well these rounds are being adhered to in addition to the senior nursing teams involvement, is through the nursing metrics which is undertaken every

month. The nursing metrics comprises a series of questions focused on specific nursing tasks and activities which the ward managers or senior nurses review each month; 10 sets of nursing and medical notes are reviewed against the specific questions asked and the results sent back to the patient safety team for analysis (Annex 1). The analyzed information is then sent back to the ward managers and their Matrons highlighting areas that may require further improvement and action. A composite set of results from all wards are sent to the Chief Nurse. Specific results from the Metrics data are discussed weekly at the senior nurse meetings including completion of comfort rounds (February 2013).

Composite Scores*	
Medication	89
Pain	87
Observations	86
Fluid Balance	65
Pressure Damage	90
Falls	91
Nutrition	88
Intravenous Lines	82
Catheters	86
Comfort Round	89
Transfer	35
Discharge Planning	78

* A composite measure excludes all of the non-applicable responses and calculates the percentage of questions where the response was "yes".

■ Yes ■ No

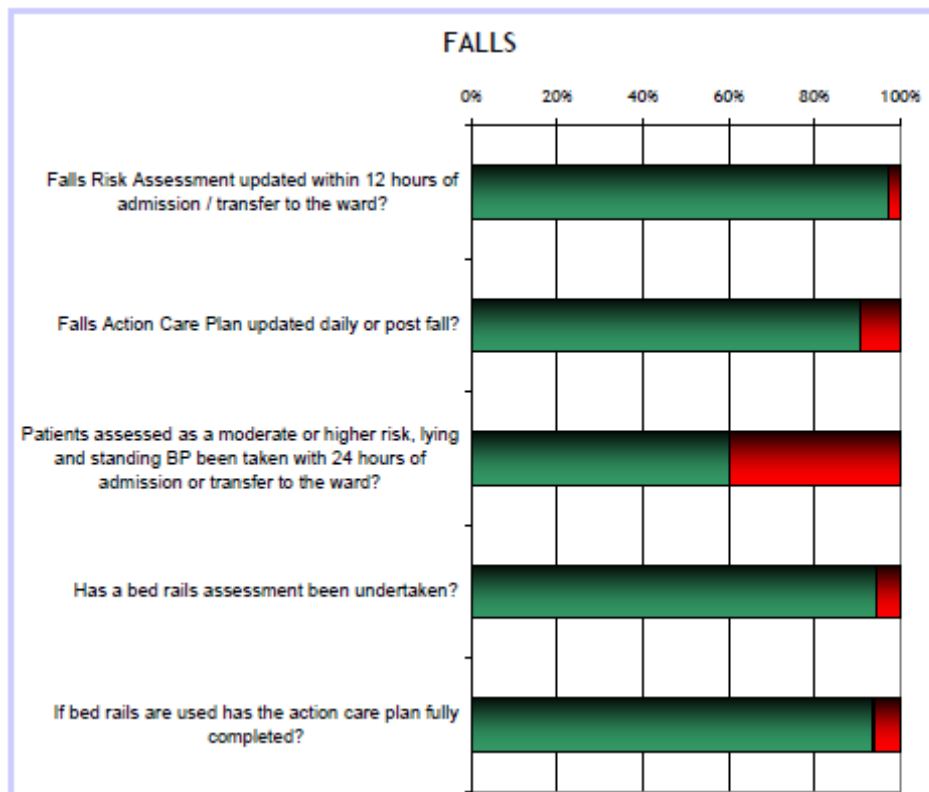


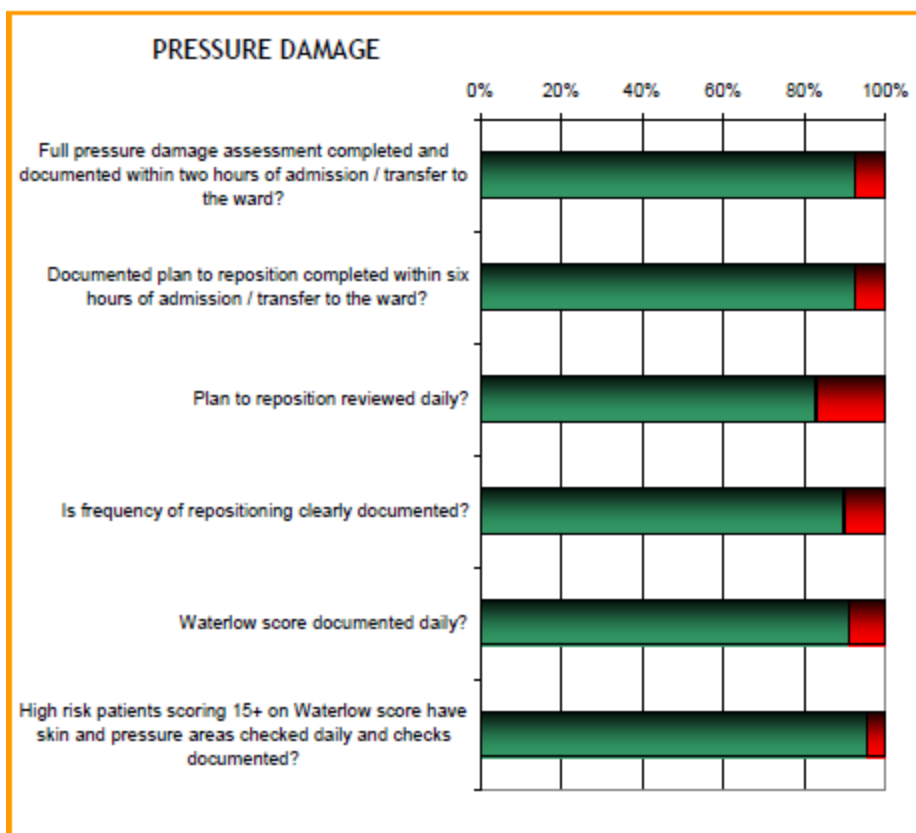
The introduction of 'bedside handover' has proven a very effective tool in involving patients in decision making about their day to day nursing care. In addition to a short traditional handover of patient information that all staff on the ward need to know, a more detailed bedside handover is

undertaken between the nursing staff changing shifts. This ensures the patients are able to clearly identify who is looking after them for the day/night and allows the patient to be involved in the discussion about their care, making it as patient centered as possible. It also allows the patients' to identify any concerns or worries they may have to the nurse looking after them about aspects of their care.

For patients who have cognitive impairment and therefore may not be able to tell us specific information about themselves, the Trust uses the 'This is Me' document (Annex 2). This is usually completed by patient's relatives/carers and shares with the nursing team patient likes, dislikes and behaviors that will help the nursing team deliver the highest standard of patient centered care.

The nursing focus on delivering person centered care has also seen improvements in reducing pressure damage and a reduction in falls. The falls reduction has been a sustained piece of work over the last 4 years that has produced effective results in reducing falls. The results for February 2013 for falls and pressure damage are included below:





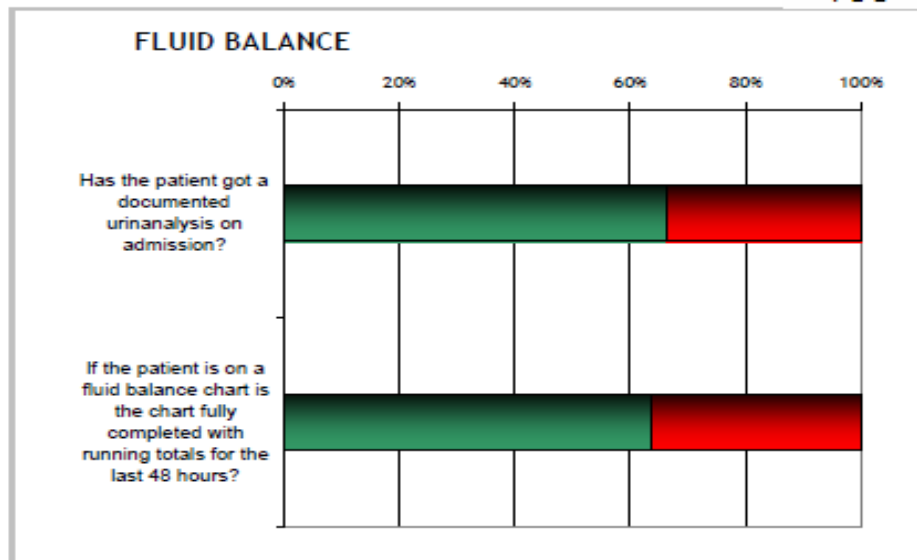
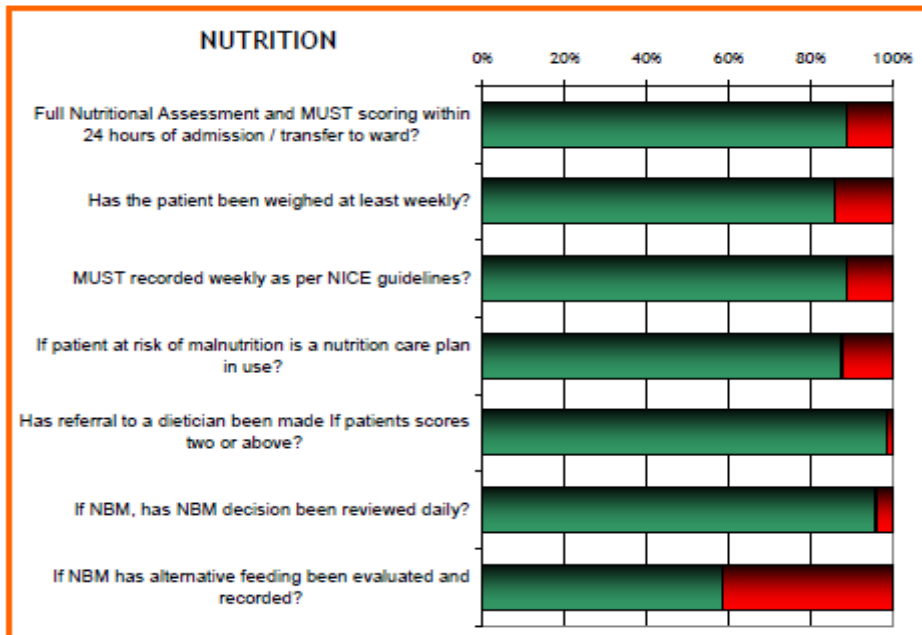
Nutrition to support Dignity in Care

There are a number of initiatives involving nutrition and hydration that assist in preserving patients' dignity within the Trust in addition to ensuring adequate nutrition and hydration are being received by patients. These include picture menus for patients with cognitive impairment; large print menus for patients with visual difficulties; coloured jugs that without the need for specific signage around the patients bed area, inform the nursing staff which patients require encouragement with taking fluids and those on limited fluid intake (this initiative was nationally recognized at the 7th Improving Nutrition and Hydration National Conference at the Royal College of Nursing in May 2011); 'dining companions' - volunteers who support wards at mealtimes (currently being rolled within the Older Peoples wards).

Creation of a Nutrition Co-ordinator sheet (Annex 3) which is completed and updated daily by the senior nurse on duty. This sheet gives the detailed information to the kitchen staff with regard to individual patient nutritional and hydration needs. A member of the nursing team is allocated this responsibility each shift and it is their responsibility to ensure the sheet is updated through the day if patients requirements change. For larger wards there may be more than one nurse allocated this responsibility.

The new catering contract with Sodexo commenced on 1st December 2012 and this has afforded the opportunity to review menus and provide a greater range of modified consistency and special diets to meet patient needs. These changes are currently being implemented and patient satisfaction feedback continues to be monitored and actioned.

The Trust also operates Protected Mealtimes to ensure nursing staff can focus specifically on ensure patients who require support with eating and drinking are prioritized which is regularly audited. Additional nutrition and hydration information is recorded and audited through the Nursing Metrics (February 2013).

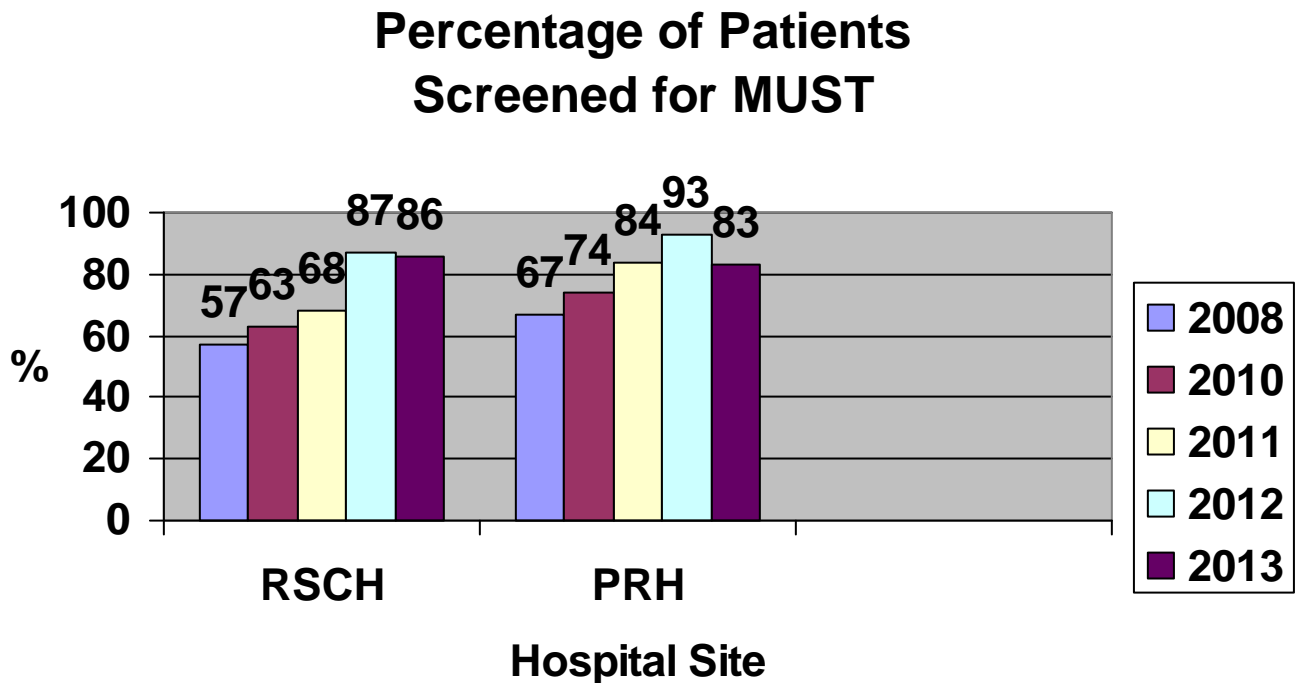


Malnutrition Matters Campaign December 2012

During December 2012 the Dietetic Department with the support of nursing, Speech and Language Therapy and Occupational Therapy colleagues ran a 'Malnutrition matters' campaign. This included disease specific updates at ward level (with a particular focus with regards to dementia). They also provided refresher MUST (Malnutrition Universal Screening Tool) training, protected mealtimes and hydration updates. There were sessions provided from Occupational Therapy regarding specialized feeding aids and from the Speech and Language Therapy team on dysphagia.

MUST results 2013

There has unfortunately been a drop in the figures for MUST screening and further ward based training has been implemented.



Patient Voice – listening to what patients and carers have to say about Dignity

The Trust uses a Patient Voice questionnaire to gain patient views (Annex 4). These questionnaires are given out to patients/relative carers, with a self sealing envelope which they can post in special patient voice post boxes in all wards and clinical areas. These are picked up by the patient voice team and results shared with the ward/unit managers and a composite set of results send to the Chief Nurse. The ward managers look closely at these results and where

necessary will implement change to practice or processes, fully taking on board suggestions and comments from patients/carers. These changes are then displayed on the ward notice boards for patient's relatives and staff to see on posters titled 'You said – We did'. These results are more widely discussed at the senior nurse weekly meeting if changes need to be made Trust wide.

Care Campaign

This is a joint venture between the Patients Association, the Nursing Standard and representatives from the Royal Colleges with 10 priorities for action; these focus on high quality patient centred care, reducing bureaucracy, improving staffing levels and developing and investing in nurse leaders. The Head of Nursing for Older People leads on the campaign and below are a selection of initiatives that are in place or being rolled out to support Dignity in Care. The campaign focus is based on the four most common complaints that the Patient Association receives and has given rise to 'The Care Challenge' of which there are 4 cornerstones:

- C – Communicate with compassion
- A – Assist with toileting, ensuring dignity
- R – Relieve pain effectively
- E – Encourage adequate nutrition

'The most common of all complaints received by the Patients Association is about poor communication and poor staff attitude'

The table overleaf details the work undertaken in the areas of; Nutrition, Communication, Assisting with Toileting and Relieving Pain Effectively.

<p><u>Nutrition – Ann Gibbins</u></p> <ul style="list-style-type: none"> • Mission for Nutrition – picture menus • Coloured jugs and beakers • Dining Companions – volunteers/carers • SALT/Dietician joint working on Top Tips and Discharge leaflets • Nutrition Co-ordinators on every ward every shift • Protected Mealtimes • Tuck Bags 	<p><u>Communication – Claire Martin</u></p> <ul style="list-style-type: none"> • Communication Boxes • ‘Key Ring’ • Older People and Dignity Champions • Essence of Care • Surgeries for sign off mentors • Signage • Volunteers on front desk – ‘Pathfinders’ • Reviewing nurse leadership programmes • Publishing – local and national
<p><u>Assisting with Toileting – Paula Tucker</u></p> <ul style="list-style-type: none"> • Comfort rounds • Ladders and Bladders • Catheter challenge • E-learning module on continence • E-Learning module on catheterisation • Campaign Drive – ‘Can you wee next to me’ and ‘Commode Code’ 	<p><u>Relieve Pain Effectively – Wendy Caddy</u></p> <ul style="list-style-type: none"> • Stop it and Spot it drive • New pain assessment algorithm • Bespoke education for clinical areas • Mandatory requirement on ward induction • Review drug charts

15 Steps Challenge

The 15 Steps Challenge is a series of toolkits which are part of the resources available for the Productive Care workstream. They have been co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help look at care in a variety of settings through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like. The Challenge toolkits help to gain an understanding of how patients and service users feel about the care provided and what gives them confidence. It can also help organisations to understand and identify the key components of high quality care that are important to patients, services users and carers from their first contact with a care setting.

The purpose of the 15 Steps Challenge is:

- to help staff, patients, service users and others to work together to identify improvements that can enhance the patient or service user experience

- to provide a way of understanding patients' and service users' first impressions more clearly
- a method for creating positive improvements and dialogue about the quality of care.

BSUH Trust has actively engaged in this exercise using senior nurses and members of the executive teams and other allied health professionals to undertake these audits. Simply put, the auditors should be able to get a 'sense' of what the ward or unit is like within 15 steps of walking into the ward/unit. We have recently undertaken one of these audits and a snapshot of the results are attached (Annex 5). These results help inform us of changes we need to make to aspects of our care or environment or service provision to ensure our focus remains patient centred..

National Dignity Day

National Dignity Day on the 1st February saw the Trust fully engaged with going that extra mile for our patients from arranging hand massages, nail painting, hair cuts and sets, old time musical afternoons and many tea parties. It was also a time to consider dignity in respect of our colleagues and how we work together. Several areas had dignity trees, where on each leaf of the tree, someone had written what dignity meant to them.

For the Older Peoples wards, there is an open invitation for councillors to arrange to come and see for themselves the environment we work in and the care that is being delivered. Whilst we recognise particularly within the Older Peoples wards that the environment does not lend itself to well to looking after our frail elderly patients, we do not use this as an excuse for delivering unsatisfactory care. In fact, it has been the catalyst for ensuring we deliver the best and highest standards of care we possibly can.

Ann Gibbins

Head of Nursing – Older People

08th March 2013

Joy Churcher

Head of Dietetics

Annex 1

Trust Wide

Month: February
Year: 2015

Nursing Metrics

Brighton and Sussex
University Hospitals 
NHS Trust

	Yes	No	Total
MEDICATION			
Have all of the expected doses been administered or alternatively is an appropriate omission code recorded?	336 90%	38 10%	374
Has the VTE Risk Assessment in the drug chart been completed by med staff?	307 82%	67 18%	374
Have all antibiotics been prescribed and administered according to BSUH protocol?	146 88%	19 12%	165
If drugs from the critical medications list have been prescribed have they all been administered?	219 94%	15 6%	234
If Oxygen prescribed is target saturation circled?	66 100%	0 0%	66
PAIN			
Was a pain score documented on admission / transfer to the ward?	341 91%	33 9%	374
Were pain scores documented every time other vital signs were assessed?	293 80%	75 20%	368
Was PRN analgesia prescribed?	304 92%	26 8%	330
If the pain score was >3 was there evidence that analgesia was given?	144 87%	21 13%	165
OBSERVATIONS			
Minimum of two observations undertaken each day for the last week?	367 98%	7 2%	374
MEW's score calculated for every set of obs undertaken?	317 85%	57 15%	374
Were the last two sets of MEW's scores calculated accurately?	346 93%	28 7%	374
All Observations timed with relevant date?	338 90%	36 10%	374
Were all observations taken by HCA's countersigned by a trained nurse?	93 35%	176 65%	269
Respiratory rate recorded with every set of obs?	351 94%	23 6%	374
BP is recorded accurately (using arrows)?	357 95%	17 5%	374
FLUID BALANCE			
Has the patient got a documented urinalysis on admission?	169 66%	86 34%	255
If the patient is on a fluid balance chart is the chart fully completed with running totals for the last 48 hours?	86 64%	49 36%	135
PRESSURE DAMAGE			
Full pressure damage assessment completed and documented within two hours of admission / transfer to the ward?	346 93%	28 7%	374
Documented plan to reposition completed within six hours of admission / transfer to the ward?	287 93%	23 7%	310
Plan to reposition reviewed daily?	310 83%	64 17%	374
Is frequency of repositioning clearly documented?	230 90%	26 10%	256
Waterlow score documented daily?	301 91%	29 9%	330
High risk patients scoring 15+ on Waterlow score have skin and pressure areas checked daily and checks documented?	157 96%	7 4%	164
FALLS			
Falls Risk Assessment updated within 12 hours of admission / transfer to the ward?	364 97%	10 3%	374
Falls Action Care Plan updated daily or post fall?	309 91%	31 9%	340
ward?	82 60%	54 40%	136
Has a bed rails assessment been undertaken?	254 94%	15 6%	269
If bed rails are used has the action care plan fully completed?	195 94%	13 6%	208
NUTRITION			
Full Nutritional Assessment and MUST scoring within 24 hours of admission / transfer to ward?	332 89%	42 11%	374
Has the patient been weighed at least weekly?	276 86%	46 14%	322
MUST recorded weekly as per NICE guidelines?	289 89%	37 11%	326
If patient at risk of malnutrition is a nutrition care plan in use?	64 88%	9 12%	73
Has referral to a dietician been made if patients scores two or above?	68 99%	1 1%	69
If NBM, has NBM decision been reviewed daily?	23 96%	1 4%	24
If NBM has alternative feeding been evaluated and recorded?	17 59%	12 41%	29
INTRAVENOUS LINES			
Intravenous Lines - Ongoing Care Bundle Completed on each shift change?	97 81%	23 19%	120
Intravenous Lines - if inserted on the ward is rationale for insertion recorded?	137 66%	71 34%	208
Where was Intravenous Line Inserted?	206 90%	23 10%	229
Intravenous Lines - Insertion Care Bundle Completed?	201 90%	22 10%	223
Intravenous Lines - Need for line documented daily in nursing / medical notes?	0	0	0
CATHETERS			
Catheters - if inserted on the ward is rationale for insertion recorded?	65 86%	11 14%	76
Where was catheter inserted?	82 76%	26 24%	108
Catheters - Insertion Care Bundle Completed?	109 94%	7 6%	116
Ongoing Care Bundle Completed on each shift change?	105 89%	13 11%	118
Rationale for indwelling urinary catheters documented daily?	0	0	0
COMFORT ROUND			
Comfort round checklist within the notes?	354 95%	20 5%	374
Comfort round fully completed including variance for the last three days?	298 83%	63 17%	361
TRANSFER			
When the patient was transferred to your ward did they have an "Adult Patient Transfer Checklist"?	90 42%	122 58%	212
If yes was "Adult Patient Transfer Checklist" fully completed?	34 24%	109 76%	143
DISCHARGE PLANNING			
Regardless of whether the patient is medically fit, daily entries recorded every day in the purple discharge planner?	254 68%	120 32%	374
In the last 7 days is their evidence in the discharge planner that discharge has been discussed with the family / carer?	279 90%	30 10%	309



Royal College
of Nursing

Leading the fight
against dementia

Alzheimer's
Society

This is me

This leaflet will help you support me
in an unfamiliar place

Please place a photograph of yourself in the space provided.



photo

This is me is about the person at the time the document is completed and will need to be updated as necessary.

This is me should be completed by the person or persons who know the patient best and wherever possible with the person themselves.

Please refer to the back page for guidance notes to help you complete **This is me**.

My name: full name and the name I prefer to be known by

I currently live

Carer/the person who knows me best

I would like you to know

My home and family, things that are important to me

My life so far

My hobbies and interests

Things which may worry or upset me

I like to relax by

My hearing and eyesight

My communication

My mobility

My sleep

My personal care

My eating and drinking

My medication

Date completed: _____ By whom: _____

Relationship to patient: _____

In signing this document, I agree that the information in this leaflet may be shared with health and care workers.

Guidance notes to help you to complete **This is me**

This is me is intended to provide professionals with information about the person with dementia as an individual. This will enhance the care and support given while the person is in an unfamiliar environment. It is not a medical document.

This is me is about the person at the time the document is completed and will need to be updated as necessary. This form can be completed by the person with dementia or their carer with help from the person with dementia where possible.

My name: Full name and the name I prefer to be known by.

Where I currently live: The area (not the address) where I live. Include details about how long I have lived there, and where I lived before.

Carer/the person who knows me best: It may be a spouse, relative, friend or carer.

I would like you to know: Include anything I feel is important and will help staff to get to know and care for me, eg I have dementia, I have never been in hospital before, I prefer female carers, I don't like the dark, I am left handed, I am allergic to... etc.

My home and family, things that are important to me: Include marital status, children, grandchildren, friends, pets, any possessions, things of comfort. Any religious or cultural considerations.

My life so far: Place of birth, education, work history, travel, etc.

My hobbies and interests: Past or present – eg reading, music, television or radio, crafts, cars.

Things which may worry or upset me: Anything that may upset me or cause anxiety such as personal worries, eg money, family concerns, or being apart from a loved one, or physical needs, eg being in pain, constipated, thirsty or hungry.

I like to relax by: Things which may help if I become unhappy or distressed. What usually reassures me, eg comforting words, music or TV? Do I like company and someone sitting and talking with me or prefer quiet time alone? Who could be contacted to help and if so when?

My hearing and eyesight: Can I hear well or do I need a hearing aid? How is it best to approach me? Is the use of touch appropriate? Do I need eye contact to establish communication? Do I wear glasses or need any other vision aids?

My communication: How do I usually communicate, eg verbally, using gestures, pointing or a mixture of both? Can I read and write and does writing things down help? How do I indicate pain, discomfort, thirst or hunger? Include anything that may help staff identify my needs.

My mobility: Am I fully mobile or do I need help? Do I need a walking aid? Is my mobility affected by surfaces? Can I use stairs? Can I stand unaided from sitting position? Do I need handrails? Do I need a special chair or cushion, or do my feet need raising to make me comfortable?

My sleep: Usual sleep patterns and bedtime routines. Do I like a light left on and do I find it difficult to find the toilet at night? Position in bed, any special mattress, pillow, do I need a regular change of position?

My personal care: Normal routines, preferences and usual level of assistance required in the bath or, shower or other. Do I prefer a male or female carer? What are my preferences for continence aids used, soaps, cosmetics, shaving, teeth cleaning and dentures?

My eating and drinking: Do I need assistance to eat or drink? Can I use cutlery or do I prefer finger foods? Do I need adapted aids such as cutlery or crockery to eat and drink? Does food need to be cut into pieces? Do I wear dentures to eat or do I have swallowing difficulties? What texture of food is required to help, soft or liquidised? Do I require thickened fluids? List likes, dislikes and any special dietary requirements including vegetarianism, religious or cultural needs. Include information about my appetite and whether I need help to choose food off a menu.

My medication: Do I need help to take medication? Do I prefer to take liquid medication?

Dedicated to the memory of Ken Ridley, a much valued member of the Northumberland Acute Care and Dementia Group.

The Royal College of Nursing is pleased to support **This is me**.

To order extra copies call Xcalibre on 01753 535751. For general dementia queries call our Helpline on 0845 300 0336.

alzheimers.org.uk

WARD

DATE

Co-ordinator's Name:

NUTRITION CO-ORDINATOR HANDOVER SHEET FOR KITCHEN STAFF

Bed	Patient Name	NBM - Y/N	Special Diet (Diabetic/Kosher allergies etc)	Normal/Soft/Puree	Jug/Beaker Fluid Restriction	Needs to use Picture Menu	Needs assistance Y / N	Special instruction
1	A	N	Diabetic	Normal	Green / cup	Y	N	
2	B	N	None	Soft	Red /beaker Encourage	Y	Y see nurse	
3	C	N	Gluten free	Soft	Red/beaker Encourage	Y	Y - see nurse	
4	D	Y	None	Normal	N/A	N	N/A	Can eat after surgery this morning - check with co-ordinator
5	E	Y	None	Normal	N/A	N	N/A	Waiting for SALT - check with co-ordinator at lunchtime
6								
7								
8								
9								
10								
11								
12								
13								
14								

Kitchen staff – please ensure you tell co-ordinator if patients do not eat their meal

Trust Wide

Month: February
Year: 2013



	Never	Rarely	Sometimes	Very Often	Always
Is there someone on the hospital staff available to talk with about your worries and fears	0	3	40	86	140
Do you feel staff treat you with kindness and compassion	0	0	6	46	230
Are you given enough privacy when being examined or having discussions on the ward	2	4	16	45	211
Do the staff treating and examining you introduce themselves and explain their role	0	2	21	56	202
When you ask important questions regarding your treatment & care do you get understandable answers	0	3	36	90	150
Do you feel that you are being treated as an individual and that your particular needs are recognised and catered for	1	1	15	74	190
Are you being involved as much as you want to be in decisions about your treatment and care	2	3	27	86	156
Do you think the hospital staff do everything they can to manage your pain	0	1	12	47	203
If you need help from staff getting to the bathroom, toilet or commode do you get it in time	1	1	13	46	147
Do you get your medications on time	1	1	15	76	182
Are you usually seen by the same team of doctors	4	8	47	125	86
Has one member of staff said something different from another member of staff during your stay?	112	73	67	15	7

	Very Dirty	Dirty	Not Sure	Clean	Very Clean
How clean is the ward	0	1	12	90	179

	Very Poor	Poor	Acceptable	Good	Very Good
How would you rate the hospital food	17	22	79	90	65

	Extremely Unlikely	Unlikely	Neither Likely or	Likely	Extremely Likely	Don't Know
Would you recommend this hospital to a relative or friend?	0	1	12	80	185	0

Questionnaires Returned: 284

Number of completed questionnaires required each month: 475

Annex 5

Date visited	Name	Welcoming	Safe	Caring and Including	Well organised and calm	Further comments
16/01/13	Jowers ward	- Welcoming and friendly	Air mattresses stored in bathroom	A great nurse presence was noted and patients were happy and knew the names of the staff caring for them	Where is the reception area? It was not clear where visitors should go/repost to when visiting-signs required?	
			Felt very safe on ward	All posters clear and easy to read	Very calm even when there were lots of people on the ward	A patient noted they did not like the food but this was due to personal preference
			No cluttered areas		Lack of storage space for equipment but kept out of the way of patients and corridors	Visitors not always challenged by some staff on the ward as they carried on with duties.
			All air mattress patients had call bells at arms reach			

ESHT Feedback Report March 2013

Review of Nutrition, Hydration and Feeding in hospitals and Dignity In care

1. Introduction

This report provides HOSC with a further update since March 2012 on progress made by East Sussex Healthcare NHS Trust against the key recommendations made in the HOSC Review of Nutrition, Hydration and Feeding in hospitals report – September 2010.

The HOSC review focused on five key areas:

- Screening
- Protected mealtimes
- Hospital food
- Assisted eating/drinking
- Information

The report will also focus on some of the work the organisation has achieved in relation to Dignity in Care. It is important to recognise a key characteristic of dignity and respect is the ability to bring about ways of working that enable people to maintain their personality and personal relationships whilst promoting self esteem and well being.

Whilst the areas reported on are key areas within which the organisation has made significant progress this is not the sum total of developments such as the developments of individualised care for patients whom have a learning disability, or the development Patient Stories within practice.

2. Screening

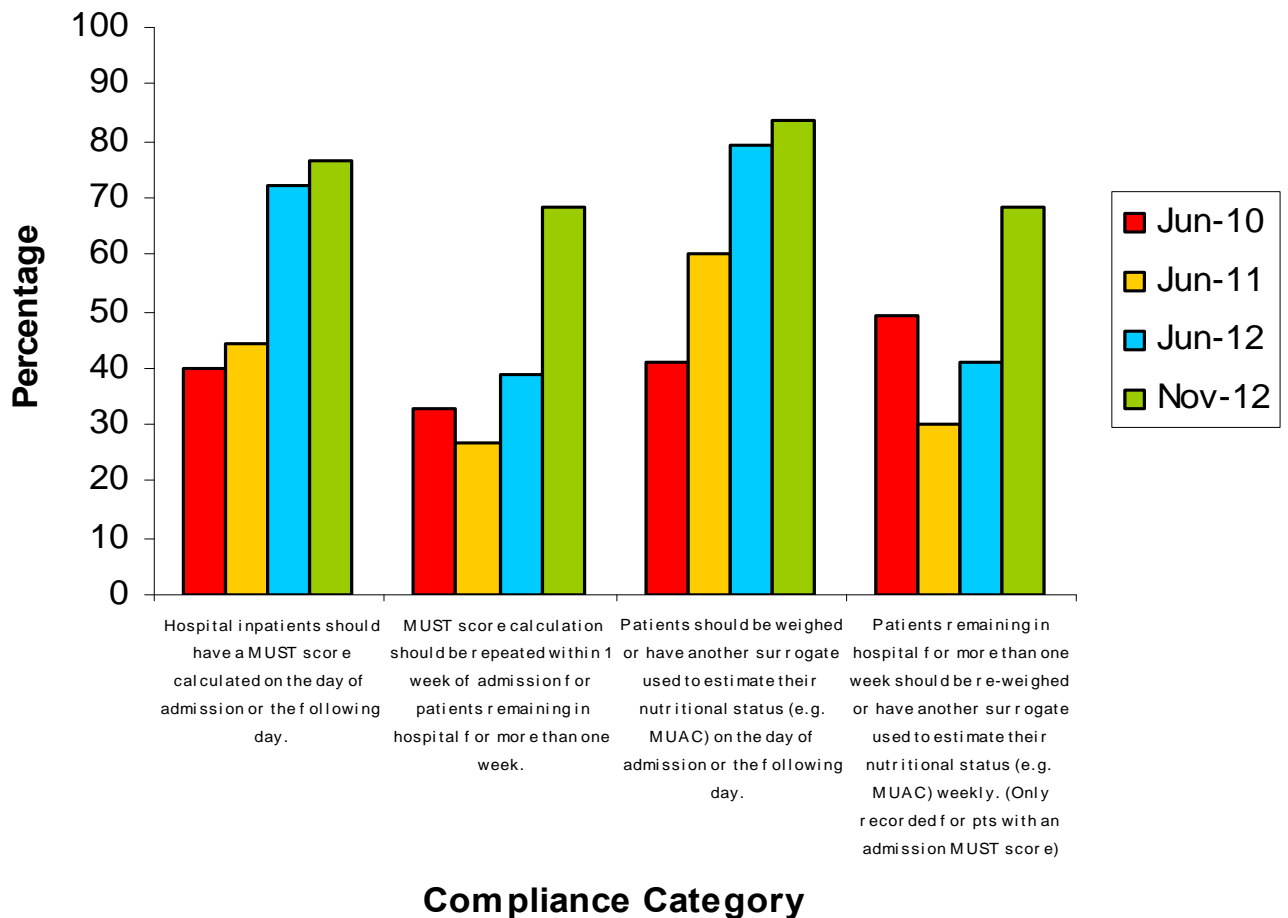
2.1 **Recommendation 1**

Trusts should continue to work towards MUST screening all inpatients and appropriate outpatients as per the NICE guidelines

Use of the Malnutrition Universal Screening Tool (MUST) is fully audited across all in patient beds annually. This last took place in June 2012 with a focused re audit undertaken on selected areas in November 2012 and reported on in December 2012.

Taking the audited wards as a representative sample of the acute hospitals, further improvement in compliance with Nutrition Screening standards and outcomes from MUST scores can be seen from the year on year data.

A graph to show the compliance of all inpatient sites in ESHT with MUST screening



2.1.1 Graph to show Changes in Compliance with standards 1-4 on acute sites (June 2010 to November 2012)

Average compliance with Nutritional Screening within 24 hours of admission was estimated at 77% (a 37% increase in compliance in 2.5 years) and weighing within 24 hours of admission was estimated at 84% (a 43% increase in the same time period).

2.1.2 Actions from 2012 audit

- Plaudits have been sent to all wards on all sites regarding universal improvements in compliance, with admission MUST and weight.
- To continue working closely with wards who have been struggling to ensure full compliance
- To review paperwork and procedure for recording actions from MUST scores across acute and community sites, currently in progress.

2.1.2 Ongoing initiatives

- Weekly documentation audits including MUST are completed by ward sisters to help ensure there is ongoing compliance.
- Dieticians supported by dietetic assistant are providing weekly MUST training sessions on wards.
- As part of the ERAS programme in pre assessment clinics MUST screening continues to be undertaken.
- MUST is included within the New Starter Health Care Assistant training and Health Care Assistant Updates.
- The next audit is planned for June 2013

2.2 Recommendation 2

Trusts should continue to work towards consistent screening for dehydration on admission. Indications for a fluid balance chart should be documented by the admitting nurse or healthcare assistant, along with an audit trail of assessment and action.

2.2.1 Actions

- A comprehensive review of a patient's hydration status is made on admission as part of the clinical history and examination process for an individual patient and this is recorded in the Integrated Patient Documentation (IPD) which forms part of the patient's clinical notes. Treatment planning will then follow on from the assessments
- This documentation is under continuous review to ensure it is fit for purpose and standardised across all sites to ensure best practise.
- The Trust supported the Nutrition and Hydration Week (23rd – 29th January 2012). The Trust won a national award from BAPEN for their work supporting and advertising this event.
- The Trust will again be participating in this event which is due to be held week commencing 18th March 2013.
- In September 2011, red jug lids were implemented on all wards to help identify patients who require help with hydration or have additional hydration needs. A Trust wide audit was undertaken in March 2012 and results showed 100% of areas have access to and were using these where appropriate.

- Essential care rounds have been implemented on all wards across the trust. These care rounds include a check on nutrition and hydration: to check - do patients have a drink, is their drink accessible to them, are they hungry and are they comfortable.

2.3 Recommendation 3

The Trusts should include reference to MUST screening within discharge checklists as an additional check to ensure that screening has taken place within the 7 days prior to discharge and any malnutrition or risk identified. Nutritional advice should be included in discharge information for GPs, other health/social care professionals and carers where appropriate.

2.3.1 Actions

- Consultants / Doctors currently provide discharge information / letter as appropriate for the GP's
- The dietetics team have been working closely with medical and nursing staff to ensure that nutrition and dietary information is provided along with all appropriate discharge information.
- There are multi disciplinary team meetings held as a minimum once per week in all areas to discuss all aspects of patients care and discharge planning. These meetings help to ensure that a comprehensive personalised care package is available for patients on discharge. This includes arrangements regarding nutrition.
- The Trusts dietetic teams have reviewed and updated processes to ensure that there is a seamless transfer of dietetic care from acute to community when required.

2.4 Recommendation 4

The Trusts should consider whether additional information on malnutrition patterns (e.g. trends in patients admitted from certain facilities) could be obtained from further analysis of data collected through MUST screening and BAPEN audits. Additional information could be used to inform the Trusts' own nutrition strategies and those of other local healthcare providers and commissioners.

2.4.1 Actions

- The Trust undertakes its own audit which is relevant to the Trust and includes all areas of the BAPEN audit.

- A dietetic representative attends the annual BAPEN conference reporting back to Trust staff the relevant and updated information.
- The Trust participates in a number of national initiatives (supported by BAPEN) such as Nutrition and Hydration week, also Coeliac Awareness week and Salt awareness week.

3. Protected Meal times

3.1 Recommendation 5

Learning and best practice with regard to embedding protected mealtimes should be more actively shared within and between local Trusts, including strategies to avoid unnecessary doctors' visits during these times.

3.1.1 Actions

- The policy has been reviewed as part of the overall Trust Clinical Nutrition Policy and is awaiting ratification.
- Protected meal times continue to be in place across the Trust in all appropriate areas.
- The protected meal time has been standardised across the organisation which is between 12pm – 1.15pm. daily.
- Protected mealtime awareness posters are available at the entrance to each ward.

4. Hospital Food

4.1 Recommendation 6

Trusts should adapt pre-mealtime routines, including encouraging patients to make use of hand gels or wipes prior to consuming meals and snacks, as part of infection control strategy.

4.1.1 Actions

- The essential care rounds implemented on all ward areas supports the pre meal preparations for patients. This includes hand washing where appropriate or the supply and use of hand wipes.
- Adaptive cutlery is available on every ward for patients who would find benefit from using it. The need for this is identified on admission to the

ward and is encouraged to promote independence. This cutlery is washed and stored on the ward to ensure it is always available for patients.

- We are currently reviewing the style of 'feed a' beakers for patients with dementia in line with national guidelines.

4.2 **Recommendation 7**

Trusts should consider action to:

a) Raise awareness of the full range of options, including vegetarian, gluten-free and diabetic menus, as well as snack boxes;

b) Increase consumption of fresh fruit and vegetables, including a visible fruit bowl at meals and refreshment breaks;

c) Take measures to ensure that food is hot for the last patient to be served;

d) Ensure that drinks are available with meals as well as afterwards.

4.2.1 **Actions**

- The Nutrition ward folder has been updated and reviewed and has been rolled out on the Eastbourne wards as part of a pilot programme for the next 6 months.
- There is an ongoing training programme in place for ward staff covering all aspects of nutrition and food awareness for patients e.g. thickening fluids, appropriate meal choices, food fortification etc.
- Training is ongoing for all new health care assistants at their induction on food hygiene and food services
- Menus are regularly reviewed and have been nutritionally assessed following guidelines from the British Dietetic Association. All of the dishes produced and served by the trust have now been nutritionally analysed and coded according to their suitability for special diet including: high energy, high protein, healthy heart, vegetarian, soft and gluten free. The coding symbols are as follows:

♥ **HH** (Healthy Heart), **HP** (High Protein), **HE** (High Energy), **V** (Vegetarian), **S** (Soft), **GF** (Gluten Free)
- Patients bed side booklets are in place and regularly reviewed.

- The special diet / supplementary menu has been reviewed following lessons learnt during the extended choice menu project to give more choice to patients who cannot eat from the main menu.
- A specialist finger food menu has been devised for patients with dementia or those who are unable to feed themselves using cutlery but still want some independence whilst eating.
- As part of the dementia strategy an acute pathway for people with a known history of living with dementia has been developed which includes guidance on safer eating and drinking.
- Extensive work is being undertaken on the provision of modified texture foods. A wider range of suitable meal options for patients who have swallowing difficulties will be introduced.

5. Assisted Eating and Drinking

5.1 Recommendation 8

Trusts should have a clear policy on assisted eating and drinking arrangements, including:

a) Agreeing and implementing a consistent Trust-wide approach to the identification of patients requiring assistance with eating or drinking – a suitable approach should be discussed with patient representatives before agreement.

b) Clarifying who provides assistance with eating in various circumstances and what training or advice should be made available to non-professionals assisting.

5.2.1 Actions

- It is the responsibility of the ward nursing teams and housekeeping teams to undertake direct feeding assistance at mealtimes. Some patients may not need physical support, but may require assistance with opening of packaging etc or indeed just friendly encouragement. This activity may be supported by volunteers.
- The Trust has purchased a range of assisted cutlery which includes high rimmed plate, non slip mats, angled spoons and thick handled cutlery and spouted cups with handles. These enable patients to maintain as much autonomy as possible at mealtimes by controlling their own food and drink consumption using approved and recognised aids. We consider this enhances the patient dignity and means that patients who require direct assistance and more practical support from nursing staff receive it.
- The Trust is currently working with Age UK to review and increase our volunteer assisted eating scheme.

5.3 Recommendation 9

Trusts should introduce more effective auditing of assisted eating and drinking procedures, including:

- a) The proportion of patients identified as requiring assistance with eating or drinking who are receiving it.*
 - b) the time between initiation of a nil by mouth order to the time of feeding being initiated (including the wait for a Speech and Language Therapy assessment, the wait for alternative tube feeding to be put in place, and the effect of delayed surgery).*
-

5.3.1 Actions

- The Trust has now funded and recruited a permanent specialist stroke dietitian for the acute sites.
- A review of dietetic care to stroke patients has been undertaken.
- Red jug lids and red trays have been implemented across the Trust. An audit was completed in December 2012 which showed that red lids and trays are available on all wards, the audit also highlighted the need to review the current guidelines.

6. Information

6.1 Recommendation 10

The Trusts should continue to develop actions to raise awareness and encourage take up of items such as fruit, snack boxes and vegetarian options. A brief reminder about the availability of additional food such as fruit and snack boxes should be included on menu cards or videos to raise awareness of these options.

6.1.1 Actions

As highlighted in recommendation 7

- The Nutrition ward folder has been updated and reviewed and has been rolled out on the Eastbourne wards as part of a pilot programme for the next 6 months.

- There is an ongoing training programme in place for ward staff covering all aspects of nutrition and food awareness for patients e.g. thickening fluids, appropriate meal choices, food fortification etc.
- Training is ongoing for all new health care assistants at their induction on food hygiene and food services
- Patients bed side booklets are place and regularly reviewed.
- The special diet / supplementary menu has been reviewed following lessons learnt during the extended choice menu project to give more choice to patients who cannot eat from main menu.
- During the Essential Care Rounds, each patient is specifically asked questions regarding nutrition e.g. If they are hungry etc. This gives the opportunity for them to have some fruit, biscuits sandwich or beverages as required.

7. Nutrition - Additional Supporting Information

- The Trust hosts an annual Nutrition Study Day which is organised by the Dietetic department. It is open to all Trust staff and is an excellent way for raising awareness and sharing best practise for good nutritional care.
- This year we undertook a study week in July 2012. This included all staff from community and acute sites. For the first time sessions were held across the county including community in patient sites.
- Community paediatric nutrition workshops were well supported with over 100 staff attending.
- Workshops held during the main study day included MUST training, care pathways for the management of gastrostomies, nutrition and dysphagia and practical management of food fortification (food first).
- Nutrition for infants: a guide to dietetic management resource was developed and training was delivered to a range of paediatric staff that would use the guidelines.
- Guidance for discharging enterally fed patients from hospital was produced. This included pathways for enteral feeding which were standardised to ensure appropriate use of ancillary equipment on discharge.

8. Dignity and Respect

8.1 Communication

- Nursing staff introduce themselves to patients on shift change and patients are informed of roles and responsibilities of the team

- Nursing staff aim to discuss all aspects of care with patients during the Essential Care Rounds which are carried out 2 hourly on each shift and when nursing interventions are carried out these are then evaluated within the integrated patient documentation and ongoing plans of care agreed.
- Nursing staff agree and document patients consent and or agreement prior to undertaking nursing interventions.
- Ward Matrons undertake weekly audits of risk assessments in their areas to ensure that all risk assessments are undertaken appropriately for each patients e.g. ensuring that their religion has been ascertained falls and bed rails risk assessments carried out and a discharge date given

8.2 Equality and Diversity

Training is in place and records being maintained at ward level as we want our patients to feel that they matter – that their values, beliefs and personal relationships will be respected. This applies to all our patients, regardless of their age, gender, ethnicity, social or cultural backgrounds, or their psychological or physical requirements.

8.3 Essential Care

- Compliance with single sex accommodation is being achieved in accordance with the national guidance. This allows clinical exceptions, where the medical care required by the individual overrides the need for single sex accommodation i.e. in ITU. This is rare on general wards and any exception is reported.
- Increase in side room capacity Wellington Ward (Conquest) additional 4 ensuite side rooms and a bariatric room.
- All wards have well fitting curtains fit for purpose and large enough to provide complete privacy.
- Placing either pegs or do not disturb signs on curtains when closed.
- Staff requesting entry prior to opening curtains.
- Patients wheeled to toilets as much as possible and especially if required at meal times.
- Separate well labelled toilet facilities for male and females.
- Toilets are well maintained and cleaned regularly.
- Toilet doors are closed when in use with the facility to open from both sides if required in an emergency.
- Patients and relatives are taken to the office / day room when possible for private conversations to be undertaken.

- Staff ensure patients are adequately dressed or covered prior to leaving a clinical area for any reason, so that their privacy is maintained and they are warm and comfortable.

8.4 Pain Management

- Pain assessments are being undertaken on admission and as part of ongoing observations of vital signs.
- Evidence that there is monitoring and evaluation of the effectiveness of pain relief.
- Use of Abbey pain score for patients with cognitive/communication impairments.
- Monitoring patients level of comfort on two hourly essential care rounds
- Involving pain team when required

8.5 Essential Care Rounds

An outcome off the work undertaken early in 2012 was the introduction of care plans to ensure that patients are involved in all aspects of their care which is evidenced by "At a Glance" documentation, an individualised summary of patient care. A second area of development to improve patient care was the introduction of Essential Care Rounds (ECRs)

The aim was to:

- systematically pilot the intentional rounding method to ensure it was fit for purpose within the local context and workplace cultures across the organisation;
- be compliant and encourage local innovation;
- build up a connected mass of clinical leaders who would own and embed the practice in their teams and services;
- make a positive contribute to the bigger organisational aims around cultural transformation through the processes underpinning this introduction.

Every ward and community hospital now carry out Essential Care Rounds every one to two hours, this method has also been adopted in the majority of our outpatient areas. The ECRs are patient centred with a nurse checking in with a patient to find out if they are comfortable and if there is anything they need. Weekly quality review meetings and our standards of care ongoing audit monitors continuing activity and benefit of carrying out ECR's.

Patients report when questioned during internal audit:

- “We see a lot more of the nurses now”
- “Staff are really busy but they always pop in every hour to check we have everything we need”
- “Staff really look after us here”

Nursing staff report:

- “This way of working means that the philosophy of our ward has changed, the aim to make sure all our patients have their needs met, and that we work individually to ensure there needs are met – and we now have a record of when we last checked that they were alright”
- “We see our patients all the time, however we can now evidence the excellent care we give”
- “We have noticed that call bells are used less on the ward”

Essential Care rounds have become part of ESHT culture; our staff have embraced this philosophy and rightfully own the realised benefits.

9. Areas of development for the coming 12 months

Within Dementia, Patient Experience and End of Life Care significant progress for the organisation has been made over the last 12 months improving the quality of care for our patients. The three key areas have launched individual ‘champions’ within clinical areas who believe passionately that being treated with dignity is an essential human right, not an optional extra. They believe that care services must be compassionate, person centered, as well as efficient, and are willing to try to do something to achieve this.

Both dementia care and End of Life Care have organisational leads and these are now starting to embed their work through the use of the ‘champion’s scheme’.

A Patient Experience Strategy is being presented to the Trust Board in March 2013 and this will underpin how we manage the future structure of patient engagement and experience.

Work is ongoing in all of these areas and will form a significant part of the programme for 2013/14.

ESHT held its first annual patient experience conference on national Dignity Day in 2013 with great success.

10. Conclusion

As outlined in this report significant progress has been made to ensure we are providing our patients with appropriate nutrition, hydration and feeding and ensuring their dignity and privacy is respected. This also supports compliance with regulatory requirements. We are not complacent and the Trust is carefully considering the findings of The Francis report published in February 2013. This report is a salutary reminder of what can happen if organisations

care more about their statutory roles and processes rather than doing what is best for patients. It is our belief that we must take this opportunity to drive the required cultural change to ensure that first and foremost we ensure the delivery of high quality care to our patients becomes part of our everyday practice.

Alice Webster
Director of Nursing
March 2013

