

# Time to listen

## In care homes

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 residents and patients 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 care homes and one for the NHS. This report describes our findings from the inspections of care homes. 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

In 2011, we carried out 100 unannounced inspections of NHS hospitals, and found that a fifth of these were failing to meet standards of dignity and nutrition on wards caring for older people. In 2012, we mirrored this programme, but this time looked at the care provided to older people across 500 care homes, including 217 homes registered to provide nursing care. Our inspections focused on respecting and involving people who use services, and meeting their nutritional needs.

Almost two-thirds (316) of the homes we inspected met all the standards we checked. This meant that staff were respecting and involving people and that people's nutritional needs were being met. To support this, homes had enough skilled and knowledgeable staff, they had taken steps to protect people from the risk of abuse, and they kept accurate records to support people's care.

## What worked well

Our inspectors found many examples of good care being provided by care homes to help make sure that people's dignity is respected and nutritional needs met.

All care home providers can learn from each other in terms of what works well. The following are some of the things highlighted by our inspectors.

We found that homes meeting the standards promoted a **culture** of care that puts residents first:

- Staff clearly understood the preferences and care needs of residents.
- Care home providers made sure the ways staff talked to and cared for people were respectful and appropriate.
- Staff saw residents as individuals and supported them to live as independently as possible.
- Care home providers made sure that social interactions between staff and residents were seen as important as providing practical care needs.

We also found that homes meeting the standards adopted the right **systems**:

- They identified and met people's preferences, care needs and nutritional needs and discussed them with residents and their families.

- They kept accurate records of each resident's care:
  - Homes that recorded people's choices and decisions about their care were more likely to be meeting the standard about involving people (91%) than those that had not (41%).
  - Homes that had recorded people's individual food and drink preferences were more likely to be meeting the standard about giving people a choice of food and drink (88%) than those that had not (41%).
- They had systems to identify people at risk of malnutrition and provided support and advice to manage and monitor the risks.
- Homes that used a formal tool to identify people at risk were more likely to be meeting the standard on nutrition: 85% of homes meeting the standard on nutrition were using a formal tool, compared to 69% homes which were not using a formal tool.
- They had processes in place to protect people from the risk of abuse and staff and people living at the home knew how to raise concerns.
- Homes used information about people's care needs to identify the number and skills and experience of staff required.
- Staff resource could be used flexibly throughout the day and was reviewed as people's needs changed.

## 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.

People living in one in six of the care homes (80 homes) we inspected did not always have their privacy and dignity respected or were not involved in their own care. Staff and managers in some homes:

- Talked to people using inappropriate words or manners.
- Did not use doors and screens when providing personal care, or did not give people somewhere to keep their possessions securely.
- Did not find out how people preferred to be cared for or spend their time.
- Failed to provide choices of activities and options for people to support their independence – particularly for people with dementia.

People living in one in six care homes (87 homes) were not always supported to eat and drink sufficient amounts. Staff and managers in some homes:

- Did not always give people a choice of food or support them to make a choice.
- Failed to identify or provide the support that people who were at risk of malnutrition needed.
- Did not ensure that there were enough staff available to support people who needed help to eat and drink: 14% of homes failed to have enough staff to meet people's needs.

Homes caring for people with dementia, including those with a dedicated dementia unit, were less likely to be meeting the standards relating to respect and safeguarding.

- Not all staff caring for people with dementia had the appropriate skills, knowledge and experience.
- Not all staff understood the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 and the implications for people they care for.

There were some differences between homes that provide nursing care and those that do not:

- More homes that provide nursing care (20%) were failing to respect and involve people than homes that do not (13%).
- More homes that do not provide nursing care were failing to meet the staffing standard (15%) than those that do (12%).

We found some links between standards not being met:

- Homes failing to respect and involve people were also more likely to be failing to meet people's nutritional needs.
- About half of the homes not meeting people's nutritional needs were also not meeting the standard about staffing.
- More than half of the homes not meeting people's nutritional needs were also not meeting the standard about record-keeping.

## Conclusions and recommendations

We are pleased to see that the majority of homes we inspected were caring for people with dignity and respect, while supporting them to make sure their nutritional needs are met.

However, it is unacceptable that too many people living in care homes are not experiencing this same level of care. In order to raise standards, providers of care homes need to make sure that:

- Older people are treated with dignity and that they are shown respect at all times. In general, this will require that greater priority is given to this aspect of care than at present.
- Individuals' needs and preferences are identified and documented on admission and regularly reviewed, with input from the individual and their relatives.
- Their staffing levels and staff skill mix reflect and meet people's identified needs. These should be reviewed on an ongoing basis to ensure that changing needs are met by a flexible workforce.
- Staff caring for people with dementia have the appropriate skills, knowledge and experience through appropriate training and access to other sources of information and support. Particular focus needs to be given to improving staff awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.



- They recognise the importance of accurate record keeping and the direct impact this has on people's experience of care. Care providers must ensure that they maintain records and documentation relating to people's needs and preferences and that these are readily available for use by staff.

Commissioners and other professional bodies also have a role to play in helping providers to raise standards of care for older people. 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.

People requiring care home services for themselves, or someone they care for, including those who fund their own care, should use the information in this report to help understand their rights and what they can expect when care is working well.

# 1. Introduction

More than 400,000 people in England live in residential care and their care requirements are becoming increasingly more complex. At the same time, the population of older people continues to grow.

We have already expressed our concerns about the extent to which care services treat older people with dignity and respect and in meeting their nutritional needs – both generally across health and social care in our 2011/12 State of Care report<sup>1</sup> and specifically in NHS hospitals in our 2011 inspection programme report.<sup>2</sup>

In 2012, we carried out two further inspection programmes looking at dignity and nutrition issues for older people. The first programme inspected 50 acute and mental health hospitals. Most of these had not been inspected in the 2011 programme; some were re-inspections of a few hospitals where we had identified concerns in the previous year. We have published a national report on these inspections at the same time as this report.<sup>3</sup>

Our second programme, between April and October 2012, looked at dignity and nutrition issues for older people living in 500 care homes across England, covering both homes that provide nursing care and those that do not. We have published a report on our website for each of the 500 homes inspected. This national report describes our overall findings from the programme and includes examples of what is working well and improvements needed.

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1 Care Quality Commission (CQC), *The state of health care and adult social care in England: An overview of key themes in care in 2011/12*, November 2012.

2 CQC, *Dignity and nutrition inspection programme: National overview*, October 2011.

3 *Time to listen: In NHS hospitals: Inspection programme 2012 – National Overview*, March 2013.

## 2. How we carried out the inspections

The themed inspections ran between April and October 2012, focusing on dignity and nutrition for older people living in care homes. This programme of inspections ran alongside our ongoing inspections of care homes in England.

### Advisory Group

The programme was supported by an Advisory Group that provided advice on the development of the methodology and key issues to focus on during our inspections. The group also helped to identify the key messages from the programme and recommendations on action required to support improvements.

Membership of the Advisory Group can be found in Appendix A.

### The sample

For this inspection programme, we selected 500 care homes (from about 11,000 registered care homes) that were:

- Providing care to older people.
- Either 'care homes with nursing' or 'care homes without nursing'.

We included some homes that had previously not met either the respect or the nutrition standard, but had since improved. The remaining homes were selected randomly from across the four CQC regions and proportionally by local authority.

We also made sure that the sample was similar to the national population in terms of:

- Proportion registered to provide services for people with dementia.
- Number of people each home is registered to accommodate.
- The size of the provider.

We excluded care homes that we had inspected in the previous six months and also those where we were following up failure to meet standards.

**Table 1**

	<b>Number inspected</b>
Homes providing nursing care	217
Homes not providing nursing care	283
Homes providing dementia care	422
Homes owned by corporate care providers	109
Corporate care providers	28

A list of the 500 homes inspected is available on our website.

## **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 records. For each standard, we identified two or three key areas (subthemes) 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 B.

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

All the inspections were unannounced. Each was scheduled to include a mealtime which our inspectors could observe. Four hundred and fifty-three inspections took place over lunchtime, 17 over the evening meal and 30 over both lunchtime and the evening meal. We carried out 10 inspections at the weekend.

## Our inspection teams

Our inspections were each led by a CQC inspector and supported overall by 96 Experts by Experience and 86 practising professionals. An Expert by Experience is someone who has experience of using or caring for someone who uses this type of service. The practising professionals included nurses, geriatricians and dietitians, and provided advice based on their relevant qualifications and experience.

**Table 2**

Number of inspections where:	
An Expert by Experience was a member of the team	397
A practising professional was a member of the team	262
Both an Expert by Experience and practising professional were members of the team	166

## Tools

To support existing CQC methods, we developed some specific tools for these inspections to gain an understanding of the experiences of people using services. These included interview questions, focusing on dignity and nutrition, to help our teams in their discussions with people who lived at the home and their relatives.

Our inspectors were also trained in, and used, the 'Short Observational Framework for Inspection 2', which is a specific way of observing people's care to help us understand the experience of those who are unable to talk with us. We used it in homes where people with dementia or communication difficulties lived.

CQC is currently looking at ways to increase the views we receive from people about their care, or the care of their relatives. To support this, we provided homes we inspected in Lancashire with leaflets so that people and visitors could give us comments about the service, which could then be considered by our inspectors when writing their reports.

# 3. Our findings

## Overall levels of homes meeting the standards

- 420 homes (84%) were meeting the standard about respecting and involving people who use services.
- 413 homes (83%) were meeting the standard about meeting nutritional needs.
- 465 homes (93%) were meeting the standard about safeguarding.
- 430 homes (86%) were meeting the standard about staffing.
- 386 homes (77%) were meeting the standard about records.
- 316 homes (63%) were meeting all the five standards we checked.

We found some links between standards not being met:

- Homes failing to respect and involve people were also more likely to be failing to meet people's nutritional needs.
- About half of the homes not meeting people's nutritional needs were also not meeting the standard about staffing.
- More than half of the homes not meeting people's nutritional needs were also not meeting the standard about record-keeping.

We also found some differences between homes that provide nursing care and those that do not, and between homes that care for people with dementia and those that do not. More homes that provide nursing care were failing to respect and involve people than homes that do not, whereas more homes that do not provide nursing care were failing to meet the staffing standard than those that do. Homes that do not care for people with dementia performed better than those that do on four out of the five standards.

**Table 3: Percentages of types of home meeting the standards**

Standard	Homes providing nursing care (217)	Homes not providing nursing care (283)	Homes caring for people with dementia (422)	Homes not caring for people with dementia (78)
Respect and involvement	80%	87%	83%	92%
Nutrition	83%	81%	82%	86%
Safeguarding	92%	94%	92%	96%
Staffing	88%	85%	85%	90%
Records	79%	75%	78%	76%

And we found some differences between corporate providers, who own more than 20 care homes, and non-corporate providers. Corporate providers performed better than non-corporates on three out of the five standards.

**Table 4: Percentages of types of home provider meeting the standards**

Standard	Corporate provider	Non-corporate provider
Respect and involvement	85%	84%
Nutrition	86%	82%
Safeguarding	92%	93%
Staffing	82%	87%
Records	81%	76%

## **Respecting and involving people who use services**

We looked at how people’s privacy and dignity were respected. We also looked at how people’s views and preferences were considered and if they were provided with opportunities to spend their time as they wished. Four hundred and twenty homes (84%) were meeting this standard; 80 homes (16%) were not.

### **Are people’s privacy and dignity respected?**

#### **What worked well**

Homes that respected people’s privacy and dignity made sure that:

- Staff had a good understanding of a person’s preferences, including their preferred name and their likes and dislikes.



- All communication with a person was respectful, using appropriate words and manners, and talking directly with them, explaining what they were doing.
- Residents had somewhere to keep their personal belongings safe and their privacy was respected, with staff knocking on doors before entering.
- People's preference for male or female care staff was respected and screens, curtains and covers were used when providing personal care or moving people.

Comments from people living at homes meeting this standard included "This is a happy place", "I can get up when I like and go to bed when I like", "I can do what I like within reason" and "I can wash and dress myself, I prefer a bath, I can have one at any time. I bath myself but the staff stay with me they are very good; I don't feel embarrassed".

### **Extracts from inspection reports**

"We observed interactions between staff and people who lived in the home. We saw that staff spoke with people in a kind way and were attentive to their needs when they requested help or appeared confused. Staff made eye contact with people when talking with them, stroked their arms gently to get their attention and calmly assisted people who needed help.

We talked with two care staff who described how they ensured people's privacy and dignity was maintained. For example, they told us that they used a towel to cover people up when they were giving them personal care to preserve their dignity. They also told us that they encouraged people to wash themselves where possible as this helped promote their independence. They described the importance of making sure that care was given in private and that, when health professionals visited the home, consultations were carried out in people's own bedrooms rather than in communal areas."

(Bethel House Care Home)

"The SOFI showed us that staff were patient and unhurried while supporting people. Where people needed more time to communicate their wishes we saw that the staff took the time to talk with them. They understood how important it was to give people the time and opportunity to express their wishes about their care and their lives in the home. We saw that, wherever possible, people were encouraged to retain as much independence as they were able with the care staff allowing time for those that did not want to be rushed." (Stilecroft Residential Home)

"People's diversity, values and human rights were respected. Staff were able to identify people who had particular cultural or religious requirements. The manager told us people were supported to practice their beliefs. There was a multi-faith room and a reminiscence room at the service."

(Farm Lane Nursing Home)

## What needs to improve

Of the 80 homes not meeting the overall standard on respect and involvement, 64 were failing to respect people's privacy and dignity. This was generally due to issues of communication, environment and preferences:

Concerns relating to communication included staff:

- Discussing people's care needs in the presence of other people living at the home.
- Moving people from one area to another without checking that they wanted to move and without telling the person why they were moving them or where.
- Using inappropriate language such as "feeders" to describe people who needed help to eat their meals.
- Having conversations between themselves while helping people to eat their meal.
- Failing to engage with people, particularly during mealtimes.

Concerns relating to the environment included the following examples:

- "One person told us that they were unable to close their bedroom door, which affected their quality of sleep and their dignity as they had to get dressed with the door open." ... "staff told us this person's door had to remain open because they were at risk of falling. No alternatives had been put in place to protect this person's dignity."
- One home had a single, large, communal living space which served as lounge and a dining room for up to 24 people. "In order to help people move around, staff had to disturb other people who were close by in order to make space."
- Leaving doors open while people used the toilet, with no attempt to use curtains or screens to maintain a person's dignity.

Concerns relating to lack of respect for people's preferences included:

- During lunchtime staff dressed each person in a disposable apron without giving them a choice. "We saw on two separate occasions people had to become quite forceful in their wish not to wear a bib before staff respected their wishes."
- Information about people's likes and dislikes had not been discussed with people or their families.

### **Extracts from inspection reports**

“People told us about how they spent their time. One person said ‘You sit around all day watching television.’ Another person said ‘I thought when we came here we could get trips out. It would be nice.’ We spoke to someone else who said, ‘I have been taken out once on a bus, that is what they should do more of’. People generally felt there was not enough to interest them. Two people commented that they felt they had no independence, and one person told us they were used to being lonely.”

“One person in the home had specific cultural and religious needs in respect of hygiene and washing. There was no information in the person’s file to guide staff on this person’s specific cultural requirements. One specific hygiene and washing requirement within their religion was to wash in running water. The home had not included this important information in their care plan to ensure staff respected this important religious requirement.”

## **Are people involved in making choices and decisions about their care?**

### **What worked well**

Homes that involved people:

- Knew people’s preferences, including their likes and dislikes, and made sure that these were met.
- Treated each person as an individual and supported them to be as independent as possible.
- Provided activities that were designed to meet people’s preferences.
- People living at the home and their families had been included in discussions and relevant information recorded in a care plan.

We found that homes that had documented people’s choices and decisions about their care were more likely to be meeting this standard (91%) than those that had not (41%).

### Extracts from inspection reports

“The manager or deputy manager carried out a detailed assessment for people prior to their admission to the home. We saw that these assessments included details about all aspects of daily living, such as people’s personal hygiene needs, nutrition, continence, medication and preferred activities. People were provided with a copy of the home’s Service Users’ Guide which included comprehensive information about the home, and the complaints procedure. The care plans were discussed with the full involvement of the person concerned, or their appointed next of kin or representative.”

(Creedy House Nursing Home)

### What needs to improve

Of the 80 homes not meeting the overall standard on respect and involvement, 63 were failing to involve people in choices and decisions about their care.

Concerns relating to preferences included homes:

- Not taking the time to find out about a person and their preferences. In some homes we spoke to people and their families who could not recall being asked about their preferences or involved in decisions about their or their relatives care.
- With care plans that did not contain relevant or up-to-date information.
- Not recording a person’s preference for male or female care staff. One person told us she had to send male care staff away as she wanted a female to attend to her personal needs.

Concerns relating to activities included homes:

- Having a lack of, or limited, activities or options for how people could spend their time. People described being bored. One person stated “It’s a pretty boring state of affairs.” Another told us “Golf and fishing are my great loves but I can’t do that here. I play scrabble sometimes but there is no one here I can play with if you know what I mean.”
- Providing activities that assumed everyone would enjoy the same thing.
- Not making their outside space and gardens available for residents to enjoy. We observed long periods with people sitting in the lounge with no stimulation or engagement from staff.

### Extracts from inspection reports

“We noted that there was very little stimulation for people using the service. Staff did not interact positively with people or engage with them in a meaningful way. We observed one member of staff come into the lounge/dining area upon starting her shift, walk past the 12 people sitting in the room without speaking or acknowledging any of them, and sit at a table. After 10 minutes had elapsed we asked the member of staff if she had spoken to any of the people using the service since she began her shift. She said she had not. We observed that staff spoke more to one another than they did with people using the service.”

## Meeting people’s nutritional needs

We checked that people’s nutritional needs were met. This included looking at the choices they were given and if they were supported to ensure they received the right food and drink to meet their nutritional needs. Four hundred and thirteen homes (83%) were meeting this standard; 87 homes (17%) were not.

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

#### What worked well

The majority of homes (442 – 88%) were providing people with a choice of food and drink to meet their nutritional needs.

Homes that gave people choice:

- Developed menus that provided a nutritionally balanced diet for people.
- Often had a monthly menu plan that had been developed with advice from a dietitian.
- Employed chefs who had a good knowledge of people’s preferences and dietary needs.
- Provided menus to residents, usually displaying them on noticeboards or on tables in the dining room. To support people with dementia, some homes used pictures or presented plated meals to help them make a choice.
- Used their knowledge of people’s preferences to provide the right meal for those unable to choose themselves.
- Could be adaptable, and provide an alternative meal for anyone who didn’t like the main one. Residents told our inspectors, “There is always enough and you can ask for more”, and “the staff will bring you sandwiches and drinks if you ask”.
- Offered drinks and snacks between meals.
- Met specific dietary requirements, including those for people who have difficulty swallowing or gluten allergies.

- Asked residents for feedback on the food and used this to make changes to the menus. One home had introduced a comments book for people to record their views.

Homes that had recorded people's individual food and drink preferences were more likely to be meeting this standard (88%) than those that had not (41%). People liked food that was well presented and served hot, and liked to be given a choice of where to eat their meal, with some preferring to eat in their rooms rather than in the dining room.

### Extracts from inspection reports

"People were being offered and provided with a choice of suitable and nutritious food and drink and there was fresh fruit and vegetables available in the kitchen. The chef told us that the kitchen could provide snacks for people when they wanted. The chef had attended training in nutritional awareness and knew the importance of providing a balanced diet. The chef was also aware of any special diets that people needed, including people who were diabetic or who had swallowing problems. The catering manager told us that all menus were first checked to ensure people received a balanced and nutritious diet." (Clore Manor Care Home)

## What needs to improve

Of the 87 homes not meeting the overall standard on meeting people's nutritional needs, 58 failed to provide a choice of suitable food and drink to people. Problems we found included homes:

- Not making suitable arrangements to support people with dementia or communication difficulties to make a choice.
- Not providing people with specific dietary needs with a suitable choice. One inspector reported, "The manager told us only one option could be provided for people who needed a pureed meal and this was often not the same meal other people received. We were told this was because only certain foods could be pureed."
- Not varying people's choice. One person told us they were consistently provided with cornflakes and jam sandwiches for breakfast and they would have liked a variety. Someone else said that the food was "alright, always the same."
- Not having enough dining space or tables to allow people to have their meal at a table if they wanted. Some people, for example, had to have their meals seated in a chair in the lounge.
- Not making sure staff knew, or recorded, people's preferences or dietary needs. In one home, we observed someone being served food from a food group they were allergic to. This information was recorded in the care plan but the cook was not aware of it.
- Not keeping a record of meals provided, or using a set of menu plans. This meant they were unable to monitor that residents were receiving a balanced diet.

### **Extracts from inspection reports**

“The service did not have a dining room and people had their meals in the lounge or in their bedrooms. Although the menu said that there was choice of meals available we saw everyone was served the same meal at lunch time. We also did not see alternatives being offered when people had eaten small amounts. The meal was plated from the kitchen, placed on a tray and brought into the lounge. It was not covered and placed onto tables in front of people. There were no condiments available to people and people did not have a choice over their meal size. People who were bed bound did not have drinks readily available to them.”

## **Are people’s religious or cultural backgrounds respected?**

The vast majority, (98%) of homes we inspected met people’s dietary requirements arising from their religious or cultural backgrounds.

### **Extracts from inspection reports**

“The six care plans that we looked at contained details of people’s dietary preferences and requirements in relation to their religious needs. Staff stated that food choices were discussed on admission and recorded in their dietary care plans and this was also communicated to staff. One person was a vegetarian and another person followed a kosher diet. The staff were aware of this and meals were provided to meet their needs.”  
(The Moorings Retirement Home)

“The home promoted people’s diversity by carrying out themed meals or days to celebrate different nationalities. The home had recently celebrated a Bulgarian day which had included Bulgarian food.”  
(Creedy House Nursing Home)

We did observe occasions when needs were not being met; this included one home that had not asked its residents about their preferences, and a cook that did not have any experience in cooking meals for people from different cultures.

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

### What worked well

The majority of homes (430 – 86%) supported people to eat and drink sufficient amounts. They:

- Knew people's support needs, and how to meet them. This included providing any adaptations or equipment required, and knowing how each person should sit to help them eat and drink, and about the best to communicate with them.
- Had systems to make sure that everyone was adequately supported. For example, people who required help to eat were served their meals first to make sure they were hot.
- Had processes to help them identify any risks of people becoming dehydrated or malnourished. This included assessing people when they first come to live at the home, and regularly updating this. Homes then sought advice from other professionals, including GPs, dietitians and speech and language therapists, on how to care for those at risk. The homes weighed these people and monitored their food and fluid intake.
- Had enough staff to support people at mealtimes at a pace that suited them. Staff could therefore:
  - Make sure residents ate enough or could be offered alternatives.
  - Cut food up for some people.
  - Give others adapted crockery to help them eat independently. Some homes used different coloured crockery to support people with dementia.
- Created the best environment for residents, so that they could sit comfortably within a relaxed, calm atmosphere, to eat well-presented meals at well-presented tables.



### Extracts from inspection reports

“We observed people being encouraged to eat and drink at meal times. Adapted crockery was provided to those who needed it. Those who required support eating and drinking were assisted appropriately and in a way that respected their dignity. The menu had choices, including pureed meals and soft meals, but other menu choices could be pureed by kitchen staff if requested”. (St Vincents House Nursing Home)

“People using the service had their weight monitored and recorded every month. The service was maintaining records of what people ate and drank at the home. People’s care plans showed that, where problems had been identified, the manager had contacted and arranged further nutritional assessments by doctors and the in-house speech and language therapist”. (Lady Sarah Cohen House Nursing Home)

“We saw staff supporting people to eat and drink, where this support was required, but also noted that wherever possible people were assisted to eat and drink independently... by the use of aids such as plate guards and specifically adapted crockery and cutlery. Arrangements were also in place for those people with swallowing or other physical difficulties including soft and pureed diets and the use of thickening agents where required”. (Eckling Grange Nursing Home)

### What needs to improve

Of the 87 homes not meeting the overall standard on meeting people’s nutritional needs, 70 were failing to support people to eat and drink sufficient amounts. Problems we found included homes:

- Not adequately assessing people’s needs or monitoring what they ate and drank – even for people who we found to be losing weight.
- Not offering any encouragement, or an alternative, to those who had not eaten any of their meal.
- Not supporting people who were struggling to eat and drink by:
  - Failing to cut up food.
  - Putting food and drink out of people’s reach.
  - Placing meals on tables that were too low.
  - Not providing adapted cutlery or plates with guards, which could support people to eat independently.
- Bringing people into the dining room too early. On one inspection, we saw 10 people who used wheelchairs seated at tables in the dining room at 11.15am.
- Not planning mealtimes. During another inspection, everyone came to the dining room at the same time, but some people did receive their meal until others had finished theirs. No one was helped to leave the dining room until everyone had finished their meal.

- Not having enough staff during mealtimes. This had a significant impact on people’s experience and often resulted in a chaotic, stressful part of the day.
- Homes that used a formal tool to identify people who may be at risk of malnutrition were more likely to be meeting the standard on nutrition (85%) than those that did not use a tool (69%).

### **Extracts from inspection reports**

“We saw that at lunchtime, one person’s table was not placed close enough to them and as a result they struggled to eat their meal. They dropped most of their food onto their clothes and were unable to use the cutlery provided to them. This person continued to eat their meal while dessert was served to others in the room and was not offered dessert when they had finished, as staff had started to clear away.

Staff started to clear the table before people had finished their meal and removed one person’s plate when they had eaten half of their meal. They did not check with the person if they had finished their meal. The person was then brought their dessert, which was jelly. The person struggled to eat it with a fork as this was the only item of cutlery placed in front of them. Although members of staff walked past this person, they did not identify that they required a spoon. On four occasions the person commented that she was struggling and eventually shouted that she needed a spoon which was then brought to her”.

## **Safeguarding people who use services from abuse**

Safeguarding is a key aspect in ensuring people’s dignity is respected and their nutritional needs are met. We checked that providers had made suitable arrangements to keep people safe and to make sure staff and people living at the home knew how to raise concerns. We also checked to see if homes were using Deprivation of Liberty Safeguards appropriately.

### **What worked well**

The majority of care homes we inspected (93%) met this standard. Care providers had trained their staff in safeguarding procedures, and staff were able to recognise potential types of abuse and knew how to report concerns. People living at these homes felt safe and confident that they could raise any concerns.

### Extracts from inspection reports

“The manager and staff spoken with confirmed that they had completed training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and were aware of how this legislation related to people using the service.

We saw three care plans included assessments under the MCA, which identified whether or not the person had capacity to make the decision about moving into residential care. Where two people had been assessed as lacking capacity, we saw that a DoLS referral had been made and that it was deemed that they were not being deprived of their liberty.”  
(Place Court)

### What needs to improve

Thirty-five homes (7%) were failing to meet this standard. For four homes, we judged this had a major impact on the people living there, and we issued warning notices that required the care home providers to take immediate action. In all cases where we identified concerns took the appropriate action to ensure people living at the home were safeguarded, including making referrals to the relevant local authority safeguarding team where necessary.

One of the homes, where we identified major impact, did not have any written procedure on what staff should do in response to an allegation of abuse. In another, our inspectors witnessed residents using intimidating and abusive language to other residents within earshot of staff, who said this had happened before but they had never reported it. On another inspection, we found staff who failed to recognise potential abuse – for example, restricting people’s movement: “Senior staff could not describe the types of abuse that may present in a care setting”.

Not all staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, and the implications for people they were caring for. This concerned us most where staff did not know where to find advice, or the manager of the home was not using the legislation appropriately to protect vulnerable people.

### Staffing

We looked at whether there were enough staff to make sure people’s privacy and dignity were respected, and that they were supported to live as independently as possible. We checked if there were enough staff available to support people at mealtimes and also that staff had the appropriate skills, knowledge and experience.

## What worked well

There were 430 care homes (86%) were meeting this standard. They:

- Identified the number of staff required by assessing the needs of the people living at the home.
- Considered the mix of different staff groups required and made sure they all had the right skills to meet people's needs.
- Deployed staff flexibly – for example at mealtimes. In one home, domestic staff assisted in the dining room to allow care staff to offer more support and time to people that required it. Our inspectors observed that “When more staff were available, people's mealtime experience improved.”
- Made sure that staff knew each resident well, including their likes and dislikes, so that they could anticipate their needs.

## What needs to improve

Seventy homes (14%) were not meeting this standard. Our most serious concerns were about homes not having enough staff to meet people's needs. Issues included homes:

- Not having enough staff during mealtimes. We saw people waiting a long time for their meals to arrive or for a member of staff to help them eat their meal. This often meant that their food became cold.
- Being slow to respond to call bells, or placing them out of people's reach.

Concerns regarding the knowledge, skills and experience of staff included:

- Staff having to focus on providing practical care needs at the expense of interacting socially with people, because they are too busy. One care worker told us “we do have enough staff but it would be good if we could spend more time with people”. Another told us “care is okay but that's it, no time to do more”.
- Staff not having the skills to care for people with dementia. Inspectors observed staff not knowing how to communicate with people with dementia, and in one home a member of staff apologised to the inspector for the behaviour of someone with dementia.

### Extracts from inspection reports

“One relative told us they felt they had to stay with their loved one as much as possible because of the lack of staff”.

“We observed people who needed assistance with eating meals in their rooms. Many people had to wait 30 minutes or more for staff assistance due to low staff numbers. Some meals were delivered to people as late as 2pm for the same reason. The delays caused people’s food to become cold. Given the fact that breakfast generally ends by 10am and the dinner meal begins at 5pm, 2pm was quite late for someone to be eating their lunch”.

“In the dining room there was one member of staff who had to help two people to eat at the same time and attended to the needs of others in the room. This meant that at times they had to interrupt helping people to eat to attend to other people’s needs. We observed that some people in the dining room were getting distressed or agitated because they were waiting for their food to arrive or because of the actions of another person taking their meal in the dining room. We observed that the member of staff in the dining room was doing their best to meet everybody’s needs but they were finding it difficult to do so”.

“While the home’s statement of purpose promotes the service as being a centre of excellence for people with dementia, we were told by the manager that only one third of the staff who worked with people with dementia had done training to help them understand the illness and how it can impact on people”.

## Records

We looked at whether providers kept accurate records for people they cared for. This included information about an individual’s preferences and any care or treatment they required. We also looked at records relating to people’s nutritional needs – particularly those with specific dietary needs. We also checked that records were kept securely and that staff could access them as required.

### What worked well

There were 386 homes (77%) meeting this standard. Homes that met this standard:

- Maintained accurate, up-to-date records that were specific to each person.
- Assessed a person’s preferences and care needs, including a nutritional assessment when they first come to live there.
- Involved residents and their families in discussions about their care.

In homes that had documented people’s choices and decisions about their care, we found they were more likely to be meeting this standard (85%) than those that had not (29%).

## What needs to improve

114 homes (23%) were not meeting this standard. While this is the highest number for any of the standards we looked at, we judged issues at most of these homes to be having a minor impact on residents' care. These issues included:

- Homes not accurately documenting information about individual residents. On the whole, staff members' knowledge counteracted this, but people's safety could be at risk if the home used agency staff, or if there were staff changes.
- Staff writing inappropriate comments in the records that were disrespectful to the person living in the home.
- Records being kept in public areas – for example, in one home, people's personal records were kept in a trolley in the conservatory. The trolley was open and accessible to anyone in the area. We also saw personal information being stored on a shelf in an area used by residents and visitors.

# 4. Follow up

## Publication and follow-up inspections

We have published reports for each of the 500 homes inspected as part of this programme. They are available at: [www.cqc.org.uk/DANI](http://www.cqc.org.uk/DANI)

For the 316 homes that were meeting all the standards no further action was required.

Where a home was not meeting a standard, we judged what impact this was having on people using the service, and then asked the care home provider 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 provider. If, on follow-up the standard is now being met, we update our website. If it's not, we consider our next actions using our enforcement policy as a guide.

We identified more serious concerns in eight homes, which meant we issued warning notices to the provider, and published corresponding press releases, which included timescales by which the standard must be met.

We carried out further inspections at each of these eight homes. We still had serious concerns at one of these so prepared to cancel its registration, but the provider voluntarily cancelled their registration. Four of these locations were found to have made improvements and were judged to be meeting the standard when we re-inspected them. We identified ongoing concerns at the other three homes and we are taking further enforcement action.

### **Extracts from follow-up inspection reports**

“Our inspection of 11 May found that people were not being protected from the risks of unsafe or inappropriate care and treatment. This was because systems in place were not effectively assessing and monitoring people’s nutritional and fluid intake. This did not ensure that people were receiving a sufficient amount of food and drink to maintain their health. We found that there was a lack of support from staff, where necessary, to enable people to eat and drink. We also identified that staff did not always treat people in a dignified way.

On this return visit (4 October) we found the provider had made the improvements required to achieve compliance with the regulations for respecting and involving people who use services, meeting people’s nutritional needs and maintaining appropriate records. Our observations and discussions with people using the service and staff confirmed that the mealtime experiences of people using the service had improved.

We spoke with three staff who told us that there had been a lot of changes made to the service since our last visit. They told us that these changes had improved the atmosphere and morale for both the people using the service and the staff.” (Barking Hall Nursing Home)

“We found that the outstanding compliance actions had been met and that people were no longer at risk of inadequate nutrition and dehydration. Staff had received training in food hygiene, healthy eating and nutrition. Records were sufficiently accurate to ensure that people received safe and appropriate care and treatment.” (Stanley Burn Care Home)

## **Evaluation**

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



# 5. Conclusions and recommendations

## Conclusions

We are pleased to see that the majority of homes we inspected were caring for people with dignity and respect, while supporting them to make choices and live as independently as possible. Most people's nutritional needs were also being met. We have identified common characteristics and practices in homes where people's needs were being met. These include examples of systems to make sure that people's preferences and needs are identified and met, and factors that promote a culture of respecting people as individuals.

However, it is unacceptable that some people living in care homes are not treated with dignity and respect or are not having their nutritional needs met. In addition to the action we are taking with individual providers it is intended that by presenting our findings in this way we can help homes make improvements where required.

## Recommendations

In order to raise standards, providers of care homes need to make sure that:

- Older people are treated with dignity and that they are shown respect at all times. In general, this will require that greater priority is given to this aspect of care than at present.
- Individuals' needs and preferences are identified and documented on admission and regularly reviewed, with input from the individual and their relatives.
- Their staffing levels and staff skill mix reflect and meet people's identified needs. These should be reviewed on an ongoing basis to ensure that changing needs are met by a flexible workforce.
- Staff caring for people with dementia have the appropriate skills, knowledge and experience through appropriate training and access to other sources of information and support. Particular focus needs to be given to improving staff awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- They recognise the importance of accurate record keeping and the direct impact this has on people's experience of care. Care providers must ensure that they maintain records and documentation relating to people's needs and preferences and that these are readily available for use by staff.

To support providers in raising the standards of care for older people, we recommend that commissioners and other professional bodies give greater priority to these aspects of care, and promote information that helps ensure people's dignity is respected and their nutritional needs are met.

People requiring care home services for themselves, or someone they care for, including those who fund their own care, should use the information in this report to help understand their rights and what they can expect when care is working well.

# Appendix A: 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:

- Mike Briggs, Association of Directors of Adult Social Services
- Janis Bryan, Expert by Experience
- Elaine Cass, Social Care Institute for Excellence
- Jenny Desoutter, Carer
- Ivy Elsey, Expert by Experience
- Margot Gosney, Royal College of Physicians
- Caroline Lecko, National Patient Safety Agency
- Stephen Lowe, Age UK
- Nicola Matthew, National Dignity Council/ Kissing it Better
- Christine McKenzie, Royal College of Nursing
- Val Hills, Royal College of Nursing
- Teresa Morrison, Carer
- Joel Sadler, POHWER (independent advocacy agency)
- Manna Santokhee, Action on Elder Abuse
- Rhonda Smith, BAPEN (British Association for Parenteral and Enteral Nutrition)
- Frank Ursell, Care Provider Alliance/ Registered Nursing Home Association

- Emma Westcott, Nursing and Midwifery Council
- Rosemary Whitehurst, Carers UK
- Emma Williams, The Relatives & Residents Association

# Appendix B: 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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