

Cwm Taf Health Board

Unannounced Dignity and Essential Care Inspection

**Date of inspection:
26 and 27 March 2012**

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1. Introduction

1.1 Article 3 of the European Convention on Human Rights says that no one shall be treated in an inhuman or degrading way¹. The Human Rights Act 1998 places public authorities in the UK – including all NHS services – under an obligation to treat people with fairness, equality, dignity and respect. Dignity is also one of the five United Nations Principles for Older People, and is a key principle underpinning both the Welsh Government’s Strategy for Older People and the National Service Framework for Older People in Wales. In 2007, the Welsh Government launched its ‘Dignity in Care Programme for Wales,’ an initiative aimed at ensuring there is zero tolerance of abuse of and disrespect for older people in the health and social care system.

1.2 Against this backdrop of international and UK human rights legislation and Welsh Government policy, in December 2011 Healthcare Inspectorate Wales (HIW) commenced a programme of unannounced ‘Dignity and Essential Care Inspections’ to review the care of people in hospitals across Wales paying particular attention to older people. This programme follows on from HIW’s Dignity and Respect Spot Checks which took place during 2009 and 2010².

1.3 The ‘Dignity and Essential Care Inspections’ review the way a patient’s dignity is maintained on a hospital ward and the fundamental, basic nursing care that the patient receives. Information is gathered through speaking to patients, relatives and staff, reviewing patient medical records and carrying out observations. More information on how the inspections are carried out is available at Appendix1 of this report.

1.4 The inspections capture a ‘snapshot’ of the care patients receive on hospital wards, which may point to wider issues about the quality and safety of essential care and dignity.

¹ ‘Inhuman treatment’ means treatment causing severe mental or physical harm, and ‘degrading treatment’ means treatment that is grossly humiliating and undignified.

² For more information on the 2009/2010 Dignity and Respect Spot Checks, please visit <http://www.hiw.org.uk/page.cfm?orgid=477&pid=47582>

1.5 On 26 and 27 March 2012, HIW undertook an unannounced Dignity and Essential Care visit to Royal Glamorgan Hospital.

Royal Glamorgan Hospital

1.6 The Royal Glamorgan Hospital is located near Llantrisant, South Wales. The hospital has around 570 beds and provides a comprehensive range of in-patient, day case and outpatient facilities together with Accident and Emergency and Diagnostic facilities.

1.7 As part of the inspection we undertook in March 2012 we visited two wards: Ward 3 which specialises in Trauma & Orthopaedic and Ward 19 which specialises in Respiratory.

2. Findings

2.1 This chapter sets out the findings from our visit.

Ward 3 Trauma and Orthopaedic

2.2 Overall the ward environment was clean and tidy, patients appeared well cared for in terms of personal care and hygiene and the ward sister provided good leadership to staff on the ward.

Ward environment

2.3 The ward was visibly clean; however, we identified a number of examples where the ward was untidy and cluttered. For example, a patient had three beakers of drink on his bedside table, none of which were fully empty.

2.4 The majority of patients that we spoke to told us that clutter on the ward was an issue due to the lack of storage space available. Patients had their own lockers but they did not provide enough storage space and were difficult to reach.

2.5 We were also informed by a number of patients that the number of cleaning staff on the ward had been reduced recently. However, all patients we spoke to informed us that they thought that the ward was clean.

2.6 Signs were clipped to curtains to inform others that care and treatment was taking place behind closed curtains. However, there were a mixture of material and disposable curtains in use on the ward and we identified that the material curtains around patient beds were short and could compromise a patient's dignity e.g. if the patient needed to use a commode.

2.7 All bathroom/toilet facilities on the ward were single gender and visibly clean. However, we did identify that one of the lock indicators on a bathroom door didn't

change colour when in use, therefore it would appear vacant when it was actually occupied.

2.8 We were pleased to see a notice board for the ward showing the ward's progress in relation to issues such as transforming care and the management of MRSA, patient falls and pressure ulcers.

Staff attitude, behaviour and ability to carry out dignified care

2.9 Staff attitudes and behaviours towards patients on the ward were excellent. We observed staff taking the time to explain things to patients and staff demonstrated an awareness of the importance of maintaining confidentiality when discussing issues with patients.

2.10 During our discussions with patients they told us that they considered staff on the ward to work very hard.

2.11 Staffing levels on the ward were below average on the ward and there was no Trauma Liaison Nurse in post. The staff we spoke to felt that a reduction in staffing levels had impacted on patient care and dignity as staff were only able to provide patients with direct basic care; however they wished they had more time to spend with patients.

2.12 We were pleased to see that a list of dignity pledges³ were available in each patient's nursing records.

³ Dignity pledges are clear and bold statements to patients regarding the standards of care they can expect during their time in hospital.

Management of patients with dementia

2.13 There was evidence of 'This is Me'⁴ being in place, which is a simple and practical tool that someone going into hospital with dementia can give to staff to help them understand their condition and needs. It provides a 'snapshot' of the person with dementia, giving information about them as an individual, such as needs, preferences, likes, dislikes and interests.

2.14 We were pleased to hear that two staff are completing the 'Dementia train the trainers' course which provides staff with an understanding of dementia, difficult/challenging behaviour and also covers how best to communicate with patients with dementia and de-escalate challenging behaviour.

2.15 We identified that the ward was using a little forget me not flower symbol on the patient board which is a Cwm Taf specific initiative used to discreetly identify patients with dementia. Initiatives such as these are noteworthy practice, however, when speaking to staff it became apparent that not all of them knew what the flower represented.

2.16 We found little evidence of any input and support from specialist dementia nurses for patients with dementia on the ward.

Care planning and provision

2.17 There was evidence in the nursing and medical records of patient assessments being carried out; however, it was difficult to find evidence of how these assessments informed the patients' care. For example, an oral assessment was carried out on a patient which identified that he should be on a mouth care plan 'B' – this entailed offering the patient mouth wash, lollies to suck and lip balm to prevent his lips being dry. However, there was no evidence that the patient had received any of this care and the patient confirmed he hadn't.

⁴ A simple and practical tool that someone going into hospital can give to staff to help them understand the condition. It provides a 'snapshot' of the person with dementia, giving information about them as an individual, such as needs, preferences, likes, dislikes and interests.

2.18 We identified that, on occasions, patient records were being completed retrospectively, therefore allowing an amount of time to pass in-between the actual care and treatment being provided and it being written up in a patient's notes. This can result in records being completed incorrectly and other nursing/medical staff not being fully informed of the care and treatment that has taken place.

2.19 We noted one patient's notes stated that the patient had been turned (changed position to reduce pressure sores) every two hours, however during our time on the ward we did not witness any of these turns taking place despite our presence on the ward for six hours.

2.20 We addressed this with the health board who, formally after our visit, wrote to us and stated that:

'Confirmation was received that the physiotherapists as well as the nursing staff were involved in turning and moving the patient. With a therapy turn, the nurses were subsequently informed and retrospectively completed the documentation. However, this has been addressed at the ward daily communication briefings and the therapists have been supported to undertake completion of the Skin Bundle documentation themselves to maintain a contemporaneous record. This will also be addressed in the senior nurses meeting for the whole Health Board.'

Records management

2.21 We were informed by staff and patients that Multi Disciplinary Team (MDT)⁵ meetings take place on the ward. However, there was no documentary evidence of these meetings have taken place.

⁵ The Multi-Disciplinary Team (MDT) is a specialist multi-professional team who make decisions together about how someone.

Fluid and nutrition

2.22 Protected meal times are in place on the ward and family members and carers are encouraged to visit to support patients during meal times if the patient requires any assistance to eat their food. One patient we spoke to was in a neck brace and was very appreciative that his spouse was permitted to come to the ward to help him during meal times.

2.23 We observed excellent preparation for meal times. Patients were positioned appropriately and bed tables were cleared, cleaned and placed within reach of patients. Also, all patients were offered hand wipes prior to their meals.

2.24 In addition, volunteers were present on the ward to assist patients during meal times.

2.25 There was no use of the red tray or red jug system on the ward which are used by many wards to identify which patients require assistance with eating and drinking. Despite this, we observed that all patients that required help to eat were provided with assistance from staff. We also identified that there was water and clean cups in range of patients and staff were encouraging patients to drink.

2.26 The majority of patients we spoke to told us that they enjoyed the food on the ward and that they were given enough time to eat.

2.27 We identified retrospective completion of fluid balance charts and we were also unsure of what the criteria was for someone being placed on a fluid balance chart. We spoke to a member of staff who told us that only patients with urinary catheters would be on a fluid chart; however, we identified a patient who had a fluid chart and did not have urinary catheter.

2.28 We also identified a patient who required assistance to drink. However, only nutrition was mentioned in his notes and there was no fluid balance chart in place.

Pressure sores

2.29 Safety crosses⁶ and SKIN bundle⁷ care plans were in place to ensure that patients get the appropriate care to reduce the risk of pressure damage.

2.30 All patients assessed as being at risk of developing pressure damage were provided with air mattresses and air cushions to help reduce the risk of sores developing.

Personal care and hygiene

2.31 Patients' clothing was clean and free from any stains and patients appeared well cared for in terms of their personal care and hygiene.

2.32 The patients we spoke to told us that they were able to wash and clean their teeth as regularly as they wanted to.

2.33 However, we identified that patient personal care monitoring forms were not always being completed by staff and also it was difficult to find evidence of oral and nail care taking place.

Toilet needs

2.34 During our time on the ward we observed staff supporting patients to use the toilet method of their choice and we witnessed staff assisting patients to and from the toilets when required.

2.35 However, during our discussions with both staff and patients we were informed that there were only two commodes available on the ward and patients had to wait for toilets to become free. A number of patients we spoke to raised concerns regarding this issue.

⁶ Safety cross is a tool used to raise awareness within team regarding how many ulcers are acquired in care area and also to promote good practice.

⁷ Skin Bundle is a simple holistic approach to ensuring that patients receive appropriate care to prevent skin damage.

2.36 Staff informed us that there was only one type of incontinent pad available on the ward. Therefore patients with different continence needs would not always have a pad that suited their individual needs.

Buzzers

2.37 A new buzzer system had recently been installed on the ward which involved a light and a sound going off when someone required assistance. However, we were unsure how effectively this system was working as sometimes there was a sound and other times just a light.

2.38 A number of concerns were raised during our time on the ward regarding buzzers. One patient told us that sometimes the buzzers do not work when patients try to call for assistance; another patient told us that other patients often used their buzzer to call for assistance for neighbouring patients and we identified two patients whose buzzers were out of reach. We informed the Health Board of this issue and were told that:

'The ward sister or deputy on each of our wards undertakes weekly call buzzer checks as regards functionality. All staff have been reminded (again) to ensure that patients can reach their buzzers and know how to use them. This will now form part of our monitoring.'

Medicines and pain management

2.39 Pain scores (measurement of pain intensity) were not consistently being completed in patient records making it difficult to assess how pain is being measured and monitored by staff.

2.40 There was also no evidence in patient care plans to indicate whether pain medication had been effective or not. Staff we spoke to stated that they do ask the patient whether the medication has had any effect; however, this conversation is not documented in the patients care plan.

2.41 One patient we spoke to stated that there had been a delay in her receiving her pain killers because the doctor had not written up the prescription for her pain medication.

2.42 We were concerned when we observed that a medicine pot with tablets in it had been left on the bedside table of a patient with dementia.

Discharge planning

2.43 Only short stay patients on the ward had been given an estimated date for their discharge and a number of patients we spoke to told us that they did not know when they were going to be discharged from hospital. This is concerning as it demonstrates that discharge planning was not being discussed or communicated to all patients, leaving some clearly unaware of the next steps. This can be extremely unsettling and cause anxiety for patients, who should be involved, along with their families and carers in discussions about planning the arrangements for their discharge.

2.44 We identified that the length of stay for patients on the ward was above average and there were a number of Delayed Transfers of Care (DTOC)⁸. We were told that the reason for the delays was due to a delay in the allocation of a social worker, although we have not been able to verify this.

Activities

2.45 Recreational activity on hospital wards (including board games, cards and bingo) can provide patients with an opportunity to improve quality of life through an increased sense of control, social interaction, social support and the accomplishment of task-orientated goals. It can also help vulnerable people develop or re-establish social skills in a controlled environment. Research⁹ has shown that activities on hospital wards have a range of positive effects on inpatients, including:

⁸ A Delayed Transfer of Care is when a patient's transfer to the next stage of care is delayed or prevented by one or more reasons.

⁹ British Medical Association, 'The psychological and social needs of patients', January 2011.

- inducing positive physiological and psychological changes in clinical outcomes;
- reducing drug consumption;
- shortening length of hospital stay;
- promoting better doctor-patient relationships; and
- improving mental health.

2.46 There were televisions and radios available in each bay. We were informed that patients bring in their own reading material and games. Other than this the provision of any stimulating activities is absent on the ward.

Ward 19 (Respiratory)

2.47 Overall, patients appeared well cared for in terms of personal care and hygiene and the Charge Nurse provided good leadership to staff on the ward. However, the ward appeared cluttered and the dark flooring and cluttered notice boards expressed the issue.

Ward environment

2.48 The ward was visibly clean and the majority of patients told us that the ward was generally clean; however, a few patients told us that the ward is often untidy. Patients also told us that cleaning staff have been reduced recently.

2.49 We identified high levels of clutter in one of the male bathrooms which created a trip hazard and also in one of the male bays. We spoke to a patient in the male bay who was severely asthmatic and told us that he felt claustrophobic and informed us that the high windows meant that he was unable to open them to access fresh air.

2.50 Signs were being used to inform others of care and treatment taking place behind closed curtains but these were not being routinely used by all staff. However, we did observe on three occasions a 'verbal knock' being used by staff prior to them entering drawn curtains.

Staff attitude, behaviour and ability to carry out dignified care

2.51 Whilst on the ward we observed staff interacting with patients in a courteous and polite manner. We observed numerous good examples set by the Charge Nurse during our time on the ward. For example we observed him explaining pain relief options to one patient in a very clear and concise manner, we also observed him turning a porter away from the ward who had come to collect a patient during a protected mealtime.

2.52 We were informed by staff that staffing levels on the ward were not always sufficient to meet the needs of patients and therefore nutrition, pressure sore care and meeting personal hygiene needs were their priorities. As with Ward 3, the staff stated that they wished they had more time to spend with patients.

Management of patients with Dementia

2.53 Staff were observed on numerous occasions responding politely and professionally to patients with dementia. The ward also had pictorial signs on bathroom and toilet doors to assist confused patients.

2.54 At the time of our visit there was no current method being used on the ward to help staff to identify patients with dementia or to help them to know and understand the needs of the patients they were caring for such as 'this is me'.

Care planning and provision

2.55 On occasions we identified a lack of knowledge from staff about the patients they were caring for, for example one nurse delivered the wrong hoist to the bedside of a patient despite clearly documenting all records detailing the hoist required. On another occasion we identified a female patient who'd been in bed for a number of days but could not find any reason for this in her notes. We spoke to a nurse who was also unaware as to why the patient had not been helped out of bed.

2.56 We raised the concern about the female patient with the health board who have, since our visit, told us:

'The patient, who had been in bed for a number of days, had been admitted with an increased confusional state. Nursing staff were engaging and negotiating with the patient on her care, however she remained very reluctant to mobilise or move out of bed and so this was an ongoing issue.'

2.57 Patients' assessments were being carried out by staff and documented in their records. However, we identified occasions where care was not being provided in accordance with the assessments.

2.58 We saw evidence in documentation viewed that The End of Life Care Pathway¹⁰ had been implemented and was being used on the ward. However, in line with an earlier example we did not observe the care that was documented in the notes. For example although the patient may have received pressure sore care and oral care in accordance to what was documented, we did not observe this care being undertaken during our time on the ward.

2.59 This particular patient was also being nursed in a bay as side rooms on the ward were not an option due to them being taken up by patients who with infection risks. We felt that this patient could have been moved to a side room in a different ward to enable him and his family more privacy, but staff didn't feel that this was in the patient's best interest.

2.60 There was a lack of individualised care planning for patients on the ward. Individualised care is essential as all patients will have varying symptoms/problems to overcome.

¹⁰ The end of life care pathway aims to ensure that high quality, person centred care is provided which is well planned and monitored taking into account the needs and wishes of the patient who is nearing the end of life.

Records Management

2.61 Overall the ward maintained a good standard of documentation. Patients' records were easy to follow and most records were up to date and completed immediately after care and treatment which was a requirement set by the Charge Nurse.

2.62 We identified one patient who had an out of date 'Do Not Attempt Resuscitation' (DNAR) form at the front of his notes, when looking at this patient's notes we noted that the patient had changed his mind and now wished to be fully resuscitated. However, the DNAR form (from a previous admission) remained at the front of his notes.

2.63 We raised this issue with the ward manager at the time of our visit and immediate action was taken.

Fluid and nutrition

2.64 Staff informed us that the roll out of protected meal times has commenced on the ward. However, we observed one consultant and his team undertaking a consultation with a patient during lunch time and nursing staff did not intervene. We also observed a porter come onto the ward to collect a patient for an x-ray. However, on this occasion the Charge Nurse intervened and gave the patient the choice to go or not. The patient did not wish to go for an x-ray during lunch time so an alternative time was arranged.

2.65 We observed patients being provided with assistance with food and fluids. Patients we spoke to also told us that staff provide assistance to patients that require help with eating their meals or drinking. We were also informed by patients that they are given enough time to eat their food at their own pace.

2.66 Patients that we spoke to told us that they always have access to water; however three of the patients we spoke to told us that the water needed to be changed more frequently, especially in the afternoon. Also, one patient who required

full assistance to drink was not seen to be being provided with regular fluids during our visit. This issue was addressed with the Charge Nurse at the time of our visit.

2.67 We did not observe patients being offered hand washing before their meal.

Pressure sores

2.68 Patient risk assessments were completed to assess the risk of patients developing pressure damage and mattresses and cushions were in use in accordance with the patient risk assessment. Also, the SKIN bundle has been introduced on the ward.

2.69 Although regular pressure area care may have been provided, for one patient, turning was not observed and there was no evidence in the notes to show that the patient was being turned as often as she should have been. This issue was raised with a Health Care Support worker and the Staff Nurse for the bay at the time who informed us that the patient had been turned.

Personal care and hygiene

2.70 Patients on the ward appeared well cared for and their personal care and hygiene needs were being met.

2.71 There was good documentation of the provision of personal care provided on the ward. The patient care monitoring forms we reviewed were all fully complete.

2.72 The majority of patients were wearing their own clothes which all appeared clean. This created a sense of normality and independence for patients on the ward.

Toilet needs

2.73 We observed staff assisting patients to and from the toilet during our time on the ward and patients told us that they were able to use the toilet method of their choice.

2.74 We observed very little commode usage and we were told by staff that, if possible, patients are helped to the toilet as opposed to using a commode at the bedside.

2.75 The ward has input and support from an incontinence nurse.

2.76 As with Ward 3, we identified an inadequate range of continence pads on the ward as there was only one type of pad available, designed for use in bed, which was not suited to meet the needs of all patients with continence issues.

Buzzers

2.77 It was observed that all patients had access to their own buzzer and that they knew how to operate the buzzers.

2.78 We were also informed by patients that staff answer buzzers as quickly as possible but the response times can vary during busy periods. We were informed by one patient that another patient had an 'accident' while waiting for a nurse to assist him to the toilet.

Medicines and pain management

2.79 The patients we spoke to told us that staff on the ward did their best to relieve or control pain. We were informed by one patient that she was able to access pain relief at 4am and we also observed the charge nurse providing pain relief options to a patient on the ward.

2.80 We were concerned to observe that the drug fridge on the ward was left unlocked which we reported to the Health Board at the time of our visit.

Discharge planning

2.81 The majority of patients we spoke to on the ward knew about their discharge date and what was planned for them after their discharge as they had been involved in the discussions.

2.82 We were informed by staff that patients on the ward have experienced delays in discharge due to a key member health and social care staff not being available. One example was when one patient had to remain in hospital longer than necessary due to the discharge meeting being postponed because a social worker was on annual leave.

Activities

2.83 There were televisions in each bay and the WRVS¹¹ trolley visits daily providing newspapers and magazines to patients. We were also informed that patients bring in their own reading material. Other than this there is no stimulating activities provided to patients on the ward.

¹¹ WRVS is a Volunteer and Charity Work organisation. Volunteers and staff run shops and cafés in hospitals.

3. Recommendations

3.1 In view of the findings arising from this review we make the following recommendations.

Ward environment

3.2 The Health Board should review storage arrangements to ensure that patient belongings and ward supplies/equipment are stored appropriately.

3.3 The Health Board must ensure that curtains used around patient beds are a suitable length in order to maintain patient privacy and dignity.

3.4 The Health Board should ensure that all staff put measures in place to inform others of care and treatment taking place behind closed curtains.

3.5 The Health Board must ensure that the broken lock on the toilet door in Ward 3 is repaired.

Staff attitude, behaviour and ability to carry out dignified care

3.6 The Health Board should provide us with assurance that staff levels on the wards visited are sufficient enough to meet the needs of the patients.

3.7 Dignity pledges were being used on Ward 3, we consider this to be noteworthy practice and recommend that the Health Board cascade this practice to other areas of the Health Board.

Management of patients with dementia

3.8 The Health Board should consider using initiatives such as 'This is Me' and the 'Forget me not flower symbol' across the Health Board ensuring that all staff understand the meaning of such initiatives.

3.9 The Health Board should ensure that Specialist Dementia Nurses routinely input into the care planning for patients with dementia on wards.

Care planning and provision

3.10 The Health Board must ensure that patient needs, identified in patient assessments, are linked into the patient's care plan.

3.11 The Health Board must ensure that care and treatment provided to patients is in accordance with their assessments.

3.12 The Health Board must ensure that all in-patients have care plans which are adapted to specific needs and that these care plans are regularly reviewed and updated.

3.13 The Health Board must ensure that all care and treatment provided to patients is routinely documented in the patient's notes immediately after it has taken place, including therapeutic turns.

3.14 The Health Board must ensure that nursing staff have knowledge of the patients they are caring for.

3.15 The Health Board must ensure that there is adequate reasoning behind a patient being left in bed and this information is documented in the patient's notes.

Record Management

3.16 The Health Board must ensure that all DNAR forms are kept up to date and if a patient changes their mind, this needs to be reflected in the documentation immediately.

3.17 The Health Board should ensure that all MDT meetings are documented.

Fluid and nutrition

3.18 The Health Board must ensure that all patients are provided with a regular supply of water throughout the day and this water is frequently refreshed.

3.19 The Health Board must ensure that there are clear criteria for patients being placed on a fluid balance chart and that charts are completed in a timely manner.

3.20 The Health Board must ensure that all patients are provided with the opportunity to wash their hands prior to meal times.

Personal care and hygiene

3.21 The Health Board must ensure that all personal care and hygiene provided to patients by staff is documented.

Toilet needs

3.22 The Health Board must ensure that there are an appropriate amount of commodes available for patients on wards.

3.23 The Health Board must ensure that there is a variety of continence pads available to meet different patient needs.

Buzzers

3.24 The Health Board must ensure that all patients have access to a fully functional buzzer at all times.

3.25 The Health Board should ensure that staff aim to answer buzzers/call bells within five minutes and provide an explanation and reassurance to patients if they are unable to do this because they are busy.

Medicine and pain management

3.26 The Health Board must ensure that patients receive pain relief in a timely manner.

3.27 The Health Board must ensure that after identifying that a patient is in pain, a pain assessment is undertaken immediately and a plan of action is put into place which is reviewed and evaluated.

3.28 The Health Board must ensure that medication is not left unattended at the patient bedside.

3.29 The Health Board must ensure that all drugs cupboards are kept secure.

Discharge planning

3.30 The Health Board should provide us with information on Delayed Transfers of Care on Ward 3 and include any plans in place to reduce these.

3.31 The Health Board should ensure that all patients have an estimated date for their discharge when they are admitted to the ward and that where appropriate their relatives are fully involved and informed in the discharge planning process.

Activities

3.32 The Health Board should consider ways to provide patients with activities and stimulation throughout their hospital stay.

4. Conclusion

4.1 Overall, we observed staff on both wards providing care to patients in a courteous and polite manner. We also saw numerous examples of staff interacting well with patients on the ward. However, we identified that the staffing levels on both wards was not always sufficient enough to meet the needs of the patients.

4.2 We were pleased to see the dignity pledges in place on Ward 3 and have recommended that this initiative is shared with other areas across the Health Board.

4.3 We were concerned to identify numerous issues regarding patient records on both wards. A number of recommendations have been included for the Health Board to consider addressing these issues.

4.4 We also identified that there were very limited activities and stimulation for patients on both wards. We have made a recommendation for the Health Board to consider ways to ensure that patients are provided with activities and stimulation throughout their hospital stay.

5. Next Steps

5.1 The Health Board is required to complete an action plan to address the key issues highlighted and submit it to HIW within two weeks of the report being published. The action plan should clearly state when and how the issues we identified on the two wards we visited have been addressed as well as timescales for ensuring the issues are not repeated elsewhere across the Health Board.

5.2 This action plan will then be published on HIW's website and monitored as part of HIW's regular monitoring process.

5.3 Healthcare Inspectorate Wales would like to thank Cwm Taf Health Board especially staff from Ward 3 and 19 who were extremely helpful throughout the inspection.

Background and Methodology for the Dignity and Essential Care Inspections

In 2009-2010 HIW carried out a number of unannounced 'Dignity and Respect Spot checks' to wards and departments which provided services to older people with mental health problems.

After each of these spot checks, we wrote to the Chief Executive of the relevant Health Board explaining our findings and highlighting areas for improvement. The Health Board then provided HIW with an 'action plan' explaining how they would develop areas we had identified as needing improvement.

For further information on HIW's 2009-2010 unannounced dignity and respect spot checks, please use the following link:

<http://www.hiw.org.uk/page.cfm?orgid=477&pid=47582>

In 2011, HIW developed a new programme of spot checks to focus on the essential care, safety, dignity and respect that patients receive in hospital.

A number of external reports published by organisations such as The Patients Association, Public Services Ombudsman for Wales, Older People's Commissioner for Wales and Wales Audit Office were reviewed as well as information from the public and previous HIW inspections. This information led to us developing an inspection methodology which focuses on the following areas:

- Patient environment.
- Staff attitude/ behaviour/ ability to carryout dignified care.
- Care planning and provision.
- Pressure sores.
- Fluid and nutrition.

- Personal care and hygiene.
- Toilet needs.
- Buzzers.
- Communication.
- Medicine management and pain management.
- Records management.
- Management of patients with confusion.
- Activities and stimulation.
- Discharge planning.

These inspections have been designed to review the care and treatment that all patients receive in hospital, especially older patients which research has proven can be particularly vulnerable during their hospital stay.

The Dignity and Essential Care Inspections

HIW's programme of 'Dignity and Essential Care Inspections' (DECI) commenced in November 2011 with a pilot inspection in the University Hospital of Wales, Cardiff.

The inspection team is made up of a HIW inspector, two practising and experienced nurses and a 'lay' reviewer.

The team uses a number of 'inspection tools' to help gather information about a hospital ward. Visits include carrying out observations, speaking to patients, carers, relatives and staff and looking at health records. The inspection tools currently being used for the DECI inspections can be found on our website:

<http://www.hiw.org.uk/page.cfm?orgid=477&pid=57445>

Once a hospital has been inspected a report of the findings is produced and presented to the Health Board who is then required to provide HIW with an action plan to address the key issues highlighted.

The Roles and Responsibilities of Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

- Making a significant contribution to improving the safety and quality of healthcare services in Wales.
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative and employee.
- Strengthening the voice of patients and the public in the way health services are reviewed.
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Government and healthcare providers that services are safe and good quality.

Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003.
- Care Standards Act 2000 and associated regulations.
- Mental Health Act 1983 and the Mental Health Act 2007.
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001.
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

HIW is one of 18 UK organisations who collectively have been designated by the UK Government as the 'National Preventative Mechanism' (NPM) under the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPACAT) to examine the treatment of people deprived of their liberty and recommendations for improvement.

Dignity and Essential Care Themes, Human Rights and Standards for Health Services in Wales

This document illustrates how the themes reviewed during a Dignity and Essential Care inspection relate to both 'Doing Well, Doing Better - Standards for Health Services in Wales and the European Convention on Human Rights.

Dignity and Essential Care Theme	European Convention on Human Rights	Doing Well, Doing Better - Standards for Health Services in Wales
Ward Environment	<p>Right to liberty and security (Article 5).</p> <p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p> <p>Right to respect for private and family life (Article 8).</p>	<p>12. Environment</p> <p>Organisations and services comply with legislation and guidance to provide environments that are:</p> <p>d) safe and secure; e) protect privacy.</p>
Staff Attitude, Behaviour and Ability to Carry out Dignified Care	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p> <p>Right not to be discriminated against (Article 14).</p>	<p>2. Equality, Diversity and Human Rights</p> <p>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:</p> <p>a) needs of individuals whatever their identity and background, and uphold their human rights.</p> <p>10. Dignity and Respect</p> <p>Organisations and services recognise and address the physical, psychological, social, cultural, linguistic, spiritual needs and preferences of individuals and that their right to dignity and respect will be protected and provided for.</p>

		<p>26. Workforce Training and Organisational Development</p> <p>Organisations and services ensure that their workforce is provided with appropriate support to enable them to:</p> <ul style="list-style-type: none"> a) maintain and develop competencies in order to be developed to their full potential; b) participate in induction and mandatory training programmes; c) have an annual personal appraisal and a personal development plan enabling them to develop their role; d) demonstrate continuing professional and occupational development; and e) access opportunities to develop collaborative practice and team working.
<p>Management of Patients with Dementia</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p> <p>Right to liberty and security (Article 5).</p> <p>Right not to be discriminated against (Article 14).</p>	<p>2. Equality, Diversity and Human Rights</p> <p>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:</p> <ul style="list-style-type: none"> a) needs of individuals whatever their identity and background, and uphold their human rights. <p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <ul style="list-style-type: none"> a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice.

<p>Care Planning and Provision</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p> <p>Right to liberty and security (Article 5).</p> <p>Right not to be discriminated against (Article 14).</p> <p>Right to freedom of expression (Article 10).</p>	<p>7. Safe and Clinically Effective Care</p> <p>Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care:</p> <p>a) based on agreed best practice and guidelines including those defined by National Service Frameworks, National Institute for Health and Clinical Excellence (NICE), National Patient Safety Agency (NPSA) and professional bodies;</p> <p>b) that complies with safety and clinical directives in a timely way; and</p> <p>c) which is demonstrated by procedures for recording and auditing compliance with and variance from any of the above.</p> <p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice;</p> <p>b) providing support to develop competence in self-care and promote rehabilitation and re-enablement; and</p> <p>c) working in partnership with other services and organisations, including social services and the third sector.</p>
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<p>Communication</p>	<p>Right to freedom of expression (Article 10).</p> <p>Right not to be discriminated against (Article 14).</p> <p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p> <p>Right to respect for private and family life (Article 8).</p>	<p>2. Equality, Diversity and Human Rights</p> <p>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:</p> <p>a) needs of individuals whatever their identity and background, and uphold their human rights.</p> <p>9. Patient Information and Consent</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing timely and accessible information on their condition, care, medication, treatment and support arrangements;</p> <p>b) providing opportunities to discuss and agree options;</p> <p>c) treating their information confidentially;</p> <p>d) obtaining informed consent, in line with best practice guidance; and</p> <p>e) assessing and caring for them in line with the Mental Capacity Act 2005 when appropriate.</p> <p>18. Communicating Effectively</p> <p>Organisations and services comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing:</p> <p>b) with patients, service users, carers and staff using a range of media and formats;</p> <p>c) about patients, service users and their carers;</p> <p>e) addressing all language and communication needs.</p>
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<p>Fluid & Nutrition</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p>	<p>14. Nutrition</p> <p>Organisations and services will comply with legislation and guidance to ensure that:</p> <p>a) patients' and service users' individual nutritional and fluid needs are assessed, recorded and addressed;</p> <p>b) any necessary support with eating, drinking or feeding and swallowing is identified and provided;</p> <p>where food and drink are provided:</p> <p>d) a choice of food is offered, which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all; and</p> <p>e) is accessible 24 hours a day.</p>
<p>Pressure Sores</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p>	<p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice.</p>

<p>Personal Care and Hygiene</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p>	<p>2. Equality, Diversity and Human Rights</p> <p>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:</p> <p>a) needs of individuals whatever their identity and background, and uphold their human rights</p> <p>10. Dignity and Respect</p> <p>Organisations and services recognise and address the physical, psychological, social, cultural, linguistic, spiritual needs and preferences of individuals and that their right to dignity and respect will be protected and provided for.</p> <p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice;</p> <p>b) providing support to develop competence in self-care and promote rehabilitation and re-enablement.</p>
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<p>Toilet Needs</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p>	<p>2. Equality, Diversity and Human Rights</p> <p>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:</p> <p>a) needs of individuals whatever their identity and background, and uphold their human rights.</p> <p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice;</p> <p>b) providing support to develop competence in self-care and promote rehabilitation and re-enablement.</p> <p>10. Dignity and Respect</p> <p>Organisations and services recognise and address the physical, psychological, social, cultural, linguistic, spiritual needs and preferences of individuals and that their right to dignity and respect will be protected and provided for.</p>
<p>Buzzers</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p> <p>Right to liberty and security (Article 5).</p>	<p>7. Safe and Clinically Effective Care</p> <p>Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care:</p> <p>b) that complies with safety and clinical directives in a timely way.</p>

		<p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice.</p>
<p>Medicine and Pain Management</p>	<p>Right not to be tortured or treated in an inhuman or degrading way (Article 3).</p>	<p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice.</p> <p>15. Medicines Management</p> <p>Organisations and services will ensure that:</p> <p>a) they comply with legislation, licensing and good practice guidance for all aspects of medicines management including controlled drugs;</p> <p>b) clinicians are qualified and trained in prescribing, dispensing and administering medicines within their individual scope of practice; and</p> <p>c) there is timely, accessible and appropriate medicines advice and information for patients, service users, their carers and staff including the reporting of drug related adverse incidents.</p>

<p>Records Management</p>	<p>Right to respect for private and family life (Article 8).</p>	<p>20. Records Management</p> <p>Organisations and services manage all records in accordance with legislation and guidance to ensure that they are:</p> <p>a) designed, prepared, reviewed and accessible to meet the required needs; b) stored safely, maintained securely, are retrievable in a timely manner and disposed of appropriately; c) accurate, complete, understandable and contemporaneous in accordance with professional standards and guidance; and d) shared as appropriate.</p>
<p>Discharge Planning</p>	<p>Right to liberty and security (Article 5).</p> <p>Right to respect for private and family life (Article 8).</p>	<p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>a) providing all aspects of care including referral, assessment, diagnosis, treatment, transfer of care and discharge including care at the end of life, in a timely way consistent with any national timescales, pathways and best practice; b) providing support to develop competence in self-care and promote rehabilitation and re-enablement; and c) working in partnership with other services and organisations, including social services and the third sector.</p>
<p>Activities</p>	<p>Right to freedom of expression (Article 10).</p> <p>Right to liberty and security (Article 5).</p>	<p>8. Care Planning and Provision</p> <p>Organisations and services recognise and address the needs of patients, service users and their carers by:</p> <p>b) providing support to develop competence in self-care and promote rehabilitation and re-enablement.</p>