Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Hywel Dda Health Board

Unannounced Dignity and Essential Care Inspection

Date of inspection 16 and 17 May 2013

Contents

1. Introduction

1.1 On 16 and 17 May 2013, Healthcare Inspectorate Wales (HIW) undertook a Dignity and Essential Care inspection at Glangwili General Hospital in Carmarthen, part of Hywel Dda Health Board.

Dignity and Essential Care

1.2 Article three of the European Convention on Human Rights says that no one shall be treated in an inhuman or degrading way[1]. 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.

1.3 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.

1.4 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 2010[2].

Methodology of the Inspection

[1] Inhuman treatment means treatment causing severe mental or physical harm, and 'degrading treatment' means treatment that is grossly humiliating and undignified.

1.5 The ‘Dignity and Essential Care Inspections’ review the way a patient’s dignity is maintained on a hospital ward/unit 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.

1.6 The inspections capture a snapshot of the care patients receive on hospital wards/units, which may point to wider issues about the quality and safety of essential care and dignity. More information on how the inspections are carried out is available at Appendix B of this report.

Glangwili Hospital

1.7 General hospital is a major acute secondary care hospital, in Carmarthen.

1.8 As part of this inspection we visited the Accident and Emergency Unit (A&E) and the Clinical Decision Unit (CDU).

2. Executive Summary

2.1 Our Dignity and Essential Care Inspection visit to Glangwili General Hospital observed several areas of noteworthy practice. We observed robust and systematic transfer of care of patients from the Accident and Emergency (A&E) department, and on the Clinical Decision Unit (CDU) we observed the unit to be well managed and commended their collaborative approach between nursing and medical colleagues working in the best interests of both patients and staff.

2.2 We have highlighted a number of areas for improvement that need to be implemented by the Health Board. Concerns were raised during our inspection around staffing levels and skills mix on the units particularly when they are busy. Both units were reported to be quiet at the time of our inspection and staffing levels were adequate. However, staff informed us that when the units are busy, staff can at

times find it difficult to spend as much time with patients as they feel is sufficient to provide them with the highest levels of personal care.

2.3 Other key issues identified from the inspection included:

- A lack of awareness demonstrated by some staff in relation to the need for discretion in communication. There were a few occasions where staff were observed giving patients sensitive information about their condition in public areas and when speaking to patients relatives on the telephone.
- Both units had recently put in place a Butterfly Scheme[3] however the scheme was yet to be fully embedded with staff. We observed a limited awareness demonstrated by a small number of staff of the initiative in place on the unit for identifying and managing patients with dementia.
- We observed staff communicating or locating staff able to communicate in the language of choice for patients, however there were limited communication aids available for patients with sensory impairments.
- No formalised system was in place to ensure patients who required food received it when their stay in the A&E unit was extended

2.4 Notwithstanding the recommendations made in this report, during our time on the units visited, we witnessed numerous occasions where the interactions between staff and patients were very positive, and staff were kind, compassionate and conversed with patients in their preferred language where possible. The majority of patients we received feedback from were complimentary about the staff attitude and behaviour.

2.5 Healthcare Inspectorate Wales would like to thank Hywel Dda Health Board and the staff of both the A&E unit and CDU who were extremely helpful throughout the inspection.

[3] The Butterfly Scheme allows people whose memory is permanently affected by dementia to make this clear to hospital staff and provides staff with a simple, practical strategy for meeting their needs.

3. Findings

3.1 We have structured our findings from the inspection around the key areas of Dignity and Essential Care for each unit visited. The recommendations arising from these findings are set out in page 14 of this report.

Accident and Emergency Unit

Unit Environment

3.2 Overall the Accident and Emergency unit (A&E) was a peaceful, clean, tidy and uncluttered environment. All cupboards were tidy and laundry was put away. Trolleys were stripped and cleaned immediately after use. There was a housekeeper who was continually cleaning the unit which contributed to a very clean and tidy environment.

3.3 The A&E unit was separated into minor and major injury areas. The minor injury area had nine spaces and the major injury area had eight. There was a pleasant main waiting room with amenities such as a vending machine for hot and cold drinks and a pay phone. The furniture was in a good state of repair and there was a working television and an audible paging system together with a visual display system that indicated waiting times. A relatives room was also available and observed to be uncluttered, and welcoming.

3.4 There were two paediatric bays, one in the minor injury area and one in the major injury area. There was a separate paediatric waiting area available which had suitable toys, games, books and a television to ensure children felt comfortable while they waited to be seen.

3.5 There were curtains around each patient bed space in the major and minor injury areas. We identified that no signs were in use to notify others that care and treatment was taking place. However, double curtains were in use which provided patients with privacy. It was noted that some staff spoke loudly during consultations

with patients and this did not provide enough privacy to the patient receiving diagnosis/ feedback.

3.6 We observed that there were a number of broken trolleys in a corridor which blocked a set of double doors, discussions with staff confirmed the broken trolleys were awaiting collection.

3.7 We observed that a storage room containing sharps which had a keypad opening system however this was left unlocked and potentially accessible by unauthorised staff or patients

3.8 There were designated toilets in the waiting rooms, all of which were unisex and accessible to wheelchair users.

Staff Attitude, Behaviour and Ability to Carry out Dignified Care

3.9 Staff on the unit were observed to be kind and sensitive to patients. We witnessed numerous examples of good interactions between staff and patients. Staff were courteous, generally discrete when talking to patients and happy to converse or find a staff member able to converse with patients in Welsh if this was preferred. The feedback we received from patients was very positive in relation to staff attitude and behaviour.

3.10 Staff were observed to be very discreet when administering personal care.

3.11 At the time of our visit staffing levels on the unit were appropriate however the unit was reported to be quieter than normal. Staff informed us that when the unit is exceptionally busy, or when patient dependency increases, it is often difficult to provide patients with the level of care that they would wish. Staff informed us that at such times, staffing levels and skills mix is sometimes inadequate given the nature of the emergency department. Staff did however report that there is a system in place to help allocate additional nursing support at exceptionally busy periods.

3.12 We were concerned to observe some medical staff speaking in a loud voice when dealing with patients and when speaking on the telephone.

3.13 During observations, we witnessed staff wearing gloves and aprons and using hand gel between patients. We also noted that all staff on duty on the unit wore identification badges as a means of identifying themselves to patients and relatives.

3.14 Our discussions with staff highlighted that staff were aware of the Protection of Vulnerable Adults (POVA) process and the majority had received formal POVA training, the minority of staff were awaiting upcoming formal training during the coming months.

Management of Patients with Confusion/ Dementia

3.15 The staff we spoke to informed us that they had either not received dementia training or had received very limited training. We noted that there is an initiative in place on the unit to identify patients with confusion or dementia and to assist staff caring for these patients however, the scheme was yet to be fully embedded with staff.

3.16 Signage was clear and concise on doors to patient facilities to assist patients, especially those with confusion or dementia, in locating them.

3.17 It was reported by staff that access to acute psychiatric support was adequate. During our time on the unit a patient presenting with psychiatric problems occupied an interview room. We observed that the patient was left alone for long periods and was lying uncomfortably across two chairs placed together despite there being spare bays available with trolleys to sleep on. This is not acceptable.

Care Planning

3.18 Staff monitored patients' conditions appropriately during our time on the unit. We witnessed documentation being reviewed and updated regularly. However,

interactions were not always recorded and staff reported that when the unit is busy it is difficult to keep documentation up to date.

Fluid and Nutrition

3.19 Patients who had been on the unit for an extensive period of time were provided with food. They were positioned properly to eat and assisted where necessary. However, discussions with staff highlighted that there was no formalised system in place for the provision of meals when patients stay had been extended, the provision was dependent on Health Care Support Worker availability, and choices could be limited.

3.20 We observed staff encouraging patients to drink fluids and fresh water was routinely made available with jugs and cups placed within easy reach of patients. However, fluid charts were not being regularly updated with oral fluids.

Pressure Sores

3.21 Pressure Sore Prediction Score (PSPS)[4] assessments were in place for patients deemed at risk of developing pressure sores and SKIN[5] bundles documentation was contained in patient notes, staff on the unit confirmed they had access to appropriate pressure relieving mattresses when required.

Personal Care and Hygiene

3.22 Patients on the unit appeared well cared for and their personal care needs were being met, staff informed us they had a supply of personal care packs containing toothbrush, toothpaste and soap available for patients to use given that often patients were not able to prepare for admission.

[4] The PSPS is a pressure ulcer risk assessment/prevention tool
[5] If a patient is deemed to be at risk of developing a pressure ulcer, the SKIN bundle requires documented nursing intervention in specific areas at least every two hours to reduce the likelihood of damage.

3.23 We did not observe patients being offered the opportunity to wash, however none of the patients on the ward had been on the unit for more than four hours.

Toilet Needs

3.24 We observed patients being helped by staff to use the toilet method of their choice.

Buzzers

3.25 Buzzers were available in all patient spaces, including in corridors and toilets. We observed all buzzers to be in working order and staff responding to buzzers promptly.

Communication

3.26 Communication on the unit was observed to be positive in both English and Welsh dependent on the patients preferred language. We were informed by staff there was no loop system available for patients with hearing impairments and we did not observe any other communication aids being used for patients with sensory impairments.

Medicines and Pain Management

3.27 Patients we spoke to did not raise any issues in relation to pain management. We identified patient records contained up to date pain assessments and there was evidence that pain intensity and effectiveness of painkillers was being managed and pain relief given appropriately.

Discharge Planning

3.27 Comprehensive, robust and systematic handovers were observed between staff on the unit and staff from receiving wards. Staff took time to discuss the patient's needs in detail.

Clinical Decisions Unit

Unit Environment

3.29 The Clinical Decisions Unit (CDU) was newly developed and purpose built. It was split into two distinct areas: a 'green area' which consisted of 14 beds, single sex and unisex toilets and shower rooms; and a 'purple area' consisting of 10 side rooms with en suite facilities including toilet, basin and shower. The reception was located in the 'purple area'. The whole unit was modern, very clean and well maintained

3.30 The unit was generally uncluttered, although some of the smaller storage rooms were found to be cluttered and in one storage room we noticed that access to the sink was restricted due to the amount of clutter.

Staff Attitude, Behaviour and Ability to Carry out Dignified Care

3.31 Staff were observed to interact with patients in a polite and respectful manner and patients told us that they were very comfortable. The patients we spoke to were very complementary of staff attitude and behaviour.

3.32 Care on the unit was well managed and dignified. Patients' privacy was maintained and the environment was positive. Staff were very discreet when administering personal care and signs were in use to notify others that care and treatment was taking place.

3.33 It was clearly evident that staff on the unit were aware of the need for discretion when communicating personal information about patients or with patients.

3.34 During our visit staffing levels on the unit were appropriate as the unit was reported to be more peaceful than normal. However, staff informed us that they were not always able to provide the level of care they would like to provide when the unit is particularly busy.

3.35 During observations, we witnessed staff wearing gloves and aprons and using hand gel between patients. We also noted that the majority of staff on duty on the unit wore an identification badge as a means of identifying themselves to patients and relatives.

3.36 Our discussions with staff highlighted that staff were aware of the Protection of Vulnerable Adults (POVA) process and the majority had received formal POVA training, the minority of staff were awaiting upcoming formal training during the coming months.

Management of Patients with Confusion/ Dementia

3.37 An initiative was in the process of being introduced on the unit to identify patients with confusion or dementia and to assist staff caring for these patients. Not all staff had received the training at the time of our visit. We observed effective care being given to a patient who had been identified as having Alzheimer's disease although communication with this patient was noted to be very loud.

3.38 There were signs on doors to assist patients, especially those with dementia, to locate them.

Care Planning and Provision

3.39 During the time of our visit we observed staff to be very visible and regularly checked and monitored patient's conditions. Documentation was updated regularly and any issues identified were managed. Patients were involved in discussions

about their treatment. Specialist advice was sought if needed and appropriate referrals were made, for example to Speech and Language Therapy.

3.40 We noted that patient choices such as their preferred name and any religious/spiritual needs were not identified in care plans.

3.41 We observed that a 'do not attempt resuscitation' (DNAR) order was appropriately recorded for one patient. However, there was no evidence within the patients records that this had been discussed with the patient's family and there did not appear to be a plan to do so.

Fluid and Nutrition

3.42 All patients on the unit were offered cooked meals. The majority of patients raised no issues in relation to the quality of the food, although some complained it was bland and cold.

3.43 We observed regular fluid being offered to patients and we identified that all patients had access to water jugs and were regularly encouraged to drink by staff.

3.44 There was a red tray system in place to indicate which patients required assistance during meal times, which was observed to be organised and used effectively.

3.45 Protected meal times were in operation on the unit.

3.46 Staff reported that nutrition is assessed when the patient is admitted. It was noted that food and fluid charts were generally completed, however in a minority of cases food and fluid charts were not fully completed.

Pressure Sores

3.47 Patient records documented patient turns and the unit had access to pressure relieving mattresses.

3.48 Pressure Sore Prediction Score (PSPS)[6] assessments were in place for patients deemed at risk of developing pressure sores and SKIN[7] bundles documentation was contained in patient notes, we found patient PSPS documentation to be up to date and staff confirmed they had access to appropriate pressure relieving mattresses when required.

Personal Care and Hygiene

3.49 We observed patients being offered the opportunity to wash and their basic hygiene needs were being met.

3.50 One patient commented that they had not had their oral hygiene attended to, and we observed one patient whose oral hygiene was not initially assessed. However, the patient's oral hygiene was discussed on handover with instructions to ensure the patient's needs were met.

3.51 We observed patients being offered the opportunity to wash their hands before meal times.

Toilet Needs

3.52 There were adequate toilet facilities on the unit, with side rooms having en suite facilities.

[6] The PSPS is a pressure ulcer risk assessment/prevention tool
[7] If a patient is deemed to be at risk of developing a pressure ulcer, the SKIN bundle requires documented nursing intervention in specific areas at least every two hours to reduce the likelihood of damage.

3.53 We observed patients being supported by staff to use the toilet method of their choice. When patients required incontinence aids, these were changed regularly ensuring the patient's dignity and care was recorded in the patients records.

Buzzers

3.54 All patients had access to a buzzer. During our time on the unit we did not observe the buzzers in use as staff were always visible. However, patients told us that when they did use the buzzer, the response from staff was swift.

Communication

3.55 Staff communicated with patients in both English and Welsh and moved easily between the two languages. There was no evidence of any communication aids for patients with visual impairments, and some staff were not aware of how to access a portable loop system for patients with hearing impairments.

3.56 Patients we spoke to on the unit informed us that staff had involved them in discussions about their care and treatment and they knew the detail of their plans of care.

Medicines and Pain Management

3.57 All patients on the unit had an up to date pain assessment and there was evidence that pain was being managed effectively.

3.58 During the medication round, we observed staff supervising patients taking their medication, and recording that the medication was taken within the patient records.

Discharge Planning

3.59 We did not observe a discharge during our time on the unit. However, most patients we spoke to on the unit had a good understanding of the next steps involved in their care and there appeared to be good support from a discharge liaison nurse.

3.60 A handover was observed and the information transferred was noted to be excellent.

4. Recommendations

4.1 Findings and associated recommendations were provided through verbal feedback throughout the inspection and more formally at the feedback meeting held at the end of the second day of the visit. Any immediate concerns emerging from the inspection were also notified to the Health Board via a management letter, following the inspection, so that immediate action could be taken.

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

Reference	Recommendation	Paragraph Reference
Unit Environment		
1.1	The Health Board should ensure that corridors and storage rooms are free of clutter which may restrict access to doors or sinks.	3.6, 3.30
1.2	The Health Board should ensure that doors to rooms which are restricted are locked after use	3.7
Staff Attitude, Behaviour and Ability to Carry out Dignified Care		
2.1	The Health Board should ensure that all staff are aware of the importance of discretion when discussing sensitive information	3.5, 3.12
2.2	The Health Board should review its current staffing levels to ensure that patient care is not compromised due to short staffing during busy periods.	3.11, 3.34
2.3	The Health Board should ensure all staff receive formal Protection of Vulnerable Adults (POVA) awareness training.	3.14, 3.36
Management of Patients with Confusion or Dementia & Patients with Mental Health/psychiatric condition.		

Reference	Recommendation	Paragraph Reference
3.1	The Health Board should ensure that there are facilities to deal with distressed patients and / or patients exhibiting psychotic symptoms including facilities for patients to sleep	3.17
3.2	The Health Board should provide dementia awareness training to all staff and continue to embed the initiative to identify patients with confusion or dementia	3.15,3.37
Care Planning and Provision		
4.1	The Health Board should ensure that all monitoring of patients is routinely documented and updated.	3.18
4.2	The Health Board should ensure that all patient choices are routinely recorded and updated by staff	3.38
4.3	The Health Board should ensure that all DNAR forms are fully completed and evidence discussions with the patient and/or the patient's family.	3.41
Fluid and Nutrition		
5.1	The Health Board should implement a formalised system to ensure that all patients who require food during an extended stay in A&E are provided with food.	3.19
5.2	The Health Board should ensure that all fluid charts are fully completed	3.20, 3.46
Personal Care and Hygiene		
6.1	The Health Board should ensure that oral hygiene assessments are consistently completed by staff.	3.50
Communication		
7.1	The Health Board should ensure that communication aids are available on the units to assist patients with sensory impairments and that staff are aware of them.	3.26, 3.55

5. Next Steps

5.1 The Health Board is required to complete an action plan to address the key issues highlighted in this report and submit it to HIW within two weeks of the final report being published. The action plan should clearly state when and how the issues we identified on the two units 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 Hywel Dda Health Board, especially staff from A&E and CDU who were extremely helpful throughout the inspection.

Appendix A

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.

Appendix B

Background and Methodology for the Dignity and Essential Care Inspections

Healthcare Inspectorate Wales' (HIW's) programme of Dignity and Essential Care Inspections (DECI) commenced in November 2011.

The inspection team comprises a HIW inspector, two practising and experienced nurses and a *'lay'* reviewer.

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

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.

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.

Appendix C

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	Right to liberty and security (Article 5). Right not to be tortured or treated in an inhuman or degrading way (Article 3). Right to respect for private and family life (Article 8).	**12. Environment** Organisations and services comply with legislation and guidance to provide environments that are: d) Safe and secure. e) Protect privacy.
Staff attitude, behaviour and ability to carry out dignified care	Right not to be tortured or treated in an inhuman or degrading way (Article 3). Right not to be discriminated against (Article 14).	**2. Equality, diversity and human rights** Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the: a) Needs of individuals whatever their identity and background, and uphold their human rights. **10. Dignity and respect** 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.

		26. Workforce training and organisational development Organisations and services ensure that their workforce is provided with appropriate support to enable them to: 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. e) Access opportunities to develop collaborative practice and team working.
Management of patients with confusion or dementia	Right not to be tortured or treated in an inhuman or degrading way (Article 3). Right to liberty and security (Article 5). Right not to be discriminated against (Article 14).	**2. Equality, diversity and human rights** Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the: a) Needs of individuals whatever their identity and background, and uphold their human rights. **8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: 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.
Care planning and provision	Right not to be tortured or treated in an inhuman or degrading way (Article 3). Right to liberty and	**7. Safe and clinically effective care** Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care: a) Based on agreed best practice and

	security (Article 5). Right not to be discriminated against (Article 14). Right to freedom of expression (Article 10).	guidelines including those defined by National Service Frameworks, National Institute for Health and Clinical Excellence (NICE), National Patient Safety Agency (NPSA) and professional bodies; b) That complies with safety and clinical directives in a timely way. c) Which is demonstrated by procedures for recording and auditing compliance with and variance from any of the above. **8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: 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.
Communication	Right to freedom of expression (Article 10). Right not to be discriminated against (Article 14). Right not to be tortured or treated in an inhuman or degrading way (Article 3). Right to respect for private and family life (Article 8).	**2. Equality, diversity and human rights** Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the: a) Needs of individuals whatever their identity and background, and uphold their human rights. **9. Patient information and consent** Organisations and services recognise and address the needs of patients, service users and their carers by: a) Providing timely and accessible information on their condition, care, medication, treatment and support

		arrangements. b) Providing opportunities to discuss and agree options. c) Treating their information confidentially; d) obtaining informed consent, in line with best practice guidance. e) Assessing and caring for them in line with the Mental Capacity Act 2005 when appropriate. **18. Communicating effectively** Organisations and services comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing: b) With patients, service users, carers and staff using a range of media and formats. c) About patients, service users and their carers. e) Addressing all language and communication needs.
Fluid & nutrition	Right not to be tortured or treated in an inhuman or degrading way (Article 3).	**14. Nutrition** Organisations and services will comply with legislation and guidance to ensure that: a) Patients' and service users' individual nutritional and fluid needs are assessed, recorded and addressed. b) Any necessary support with eating, drinking or feeding and swallowing is identified and provided. Where food and drink are provided: d) A choice of food is offered, which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all. e) Is accessible 24 hours a day.
Pressure sores	Right not to be tortured or treated in an inhuman or degrading way	**8. Care planning and provision** Organisations and services recognise and address the needs of patients, service

	(Article 3).	users and their carers by: 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.
Personal care and hygiene	Right not to be tortured or treated in an inhuman or degrading way (Article 3).	**2. Equality, diversity and human rights** Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the: a) Needs of individuals whatever their identity and background, and uphold their human rights. **10. Dignity and respect.** 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. **8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: 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.
Toilet needs	Right not to be tortured or treated in an inhuman or degrading way (Article 3).	**2. Equality, diversity and human rights** Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and

		address the: a) Needs of individuals whatever their identity and background, and uphold their human rights. **8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: 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. **10. Dignity and respect** 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.
Buzzers	Right not to be tortured or treated in an inhuman or degrading way (Article 3). Right to liberty and security (Article 5).	**7. Safe and clinically effective care** Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care: b) That complies with safety and clinical directives in a timely way. **8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: 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.
Medicine and pain management	Right not to be tortured or treated in an inhuman or degrading way (Article 3).	**8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: 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. **15. Medicines management** Organisations and services will ensure that: a) They comply with legislation, licensing and good practice guidance for all aspects of medicines management including controlled drugs. b) Clinicians are qualified and trained in prescribing, dispensing and administering medicines within their individual scope of practice. 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.
Records management	Right to respect for private and family life (Article 8).	**20. Records management** Organisations and services manage all records in accordance with legislation and guidance to ensure that they are: 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. d) Shared as appropriate.

Discharge planning	Right to liberty and security (Article 5). Right to respect for private and family life (Article 8).	**8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: 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. c) Working in partnership with other services and organisations, including social services and the third sector.
Activities	Right to freedom of expression (Article 10). Right to liberty and security (Article 5).	**8. Care planning and provision** Organisations and services recognise and address the needs of patients, service users and their carers by: b) Providing support to develop competence in self-care and promote rehabilitation and re-enablement.

Appendix D

Action Plan Template

Reference	Recommendation	Health Board Action	Responsible Officer	Target Date
Unit Environment				
1.1	The Health Board should ensure that corridors and storage rooms are free of clutter which may restrict access to doors or sinks.			
1.2	The Health Board should ensure that doors to rooms which are restricted are locked after use			
Staff Attitude, Behaviour and Ability to Carry out Dignified Care				
2.1	The Health Board should ensure that all staff are aware of the importance of discretion when discussing sensitive information			
2.2	The Health Board should review its current staffing levels to ensure that patient care is not compromised due to short staffing during busy periods.			

Reference	Recommendation	Health Board Action	Responsible Officer	Target Date
2.3	The Health Board should ensure all staff receive formal Protection of Vulnerable Adults (POVA) awareness training.			
Management of Patients with Confusion or Dementia & Patients with Mental Health/psychiatric condition.				
3.1	The Health Board should ensure that there are facilities to deal with distressed patients and / or patients exhibiting psychotic symptoms including facilities for patients to sleep			
3.2	The Health Board should provide dementia awareness training to all staff and continue to embed the initiative to identify patients with confusion or dementia			
Care Planning and Provision				
4.1	The Health Board should ensure that all monitoring of patients is routinely documented and updated.			
4.2	The Health Board should ensure that all patient choices are routinely recorded and updated by staff			

Reference	Recommendation	Health Board Action	Responsible Officer	Target Date
4.3	The Health Board should ensure that all DNAR forms are fully completed and evidence discussions with the patient and/or the patient's family.			
Fluid and Nutrition				
5.1	The Health Board should implement a formalised system to ensure that all patients who require food during an extended stay in A&E are provided with food.			
5.2	The Health Board should ensure that all fluid charts are fully completed			
Personal Care and Hygiene				
6.1	The Health Board should ensure that oral hygiene assessments are consistently completed by staff.			
Communication				
7.1	The Health Board should ensure that communication aids are available on the units to assist patients with sensory impairments and that staff are aware of them.			