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Dear Andrew

UNANNOUNCED DIGNITY AND RESPECT VISIT: BRECON WAR MEMORIAL HOSPITAL

I write to advise you of the outcome and actions arising from the unannounced 'Dignity and Respect' visit made to Brecon War Memorial hospital on 23 and 24 October 2009 and to thank your staff for their positive and helpful contributions.

Background to Visit

As you may be aware we announced our intention to undertake such unannounced visits when we published our Three Year Programme for 2009-2012 in July of this year. The focus of these reviews is on the following four areas:

- Is consideration of dignity and respect evident in care and treatment?
- What processes are in operation to ensure that patients receive consistent quality and choice of food which meet their dietary requirements?
- How suitable is the environment of care?
- Are all appropriate services and individuals (including patients and carers) involved in care and treatment?

As part of the review process we interview staff, patients and carers; examine patient records and observe the environment and the care and treatment being provided at the time of our visit.

We also consider other policy and operational areas that might impact on safety, privacy and dignity including:

- Protection of Vulnerable Adults (POVA) awareness, systems and processes.
- Child Protection (POCA) awareness, systems and processes.
- Staffing levels and skill mix

Outcomes from visits such as this will also be used to inform; our review of the implementation of the Older Peoples National Service Framework (NSF) in Wales and validation of Healthcare Standards self-assessments. Most importantly the visits will be valuable in providing assurance to patients and the public about the quality of healthcare service provision and all management letters produced as a result of the visits will be published on our website.

Our visit to Brecon War Memorial Hospital spanned a 24 hour period betweeb Friday 23 and Saturday 24 October. This gave our reviewers the opportunity to consider the impact of ward routine and shift changes on patient dignity and to develop an understanding of the culture of the wards visited. Our visit focused on Crug ward, the EMI day hospital and a short observational visit to the Rehabilitation ward, Bannau.

Overall, staff were observed to be kind, courteous and respectful in the way they cared for patients. The overall atmosphere of the wards visited and the hospital generally was pleasant and the patients we spoke to told us that staff were caring and kind with “nothing seeming to be too much trouble”.

The Day Hospital currently provides more of a social than assessment function although we understand that plans are underway to review this. While this currently helps in addressing the psychological and social needs of patients, it does not fulfil its main purpose and impact sufficiently on the clinical assessment needs.

Was consideration of dignity and respect evident in care and treatment?

We saw a number of examples of personal care that support dignity. This was by ensuring that a number of services that should be considered as a requisite for normal living are encouraged. Examples included hair styling, chiropody, nail care and facilities for bathing/showering.

While these facilities may not be directly related to any specific physical health needs of elderly patients, it is important that psychological, spiritual and social needs are addressed because they contribute to better overall health outcomes.

Patients use their own clothing which helps detract from a potential 'institutionalised' atmosphere, although limited hospital clothing is available if the need arises. It is promising to see that even though the immediate environment is designed to serve clinical needs, patients are encouraged to treat the environment with familiarity and thus feel more 'at home'. This is of particular importance to the patients who are there for longer periods.

In general this trend towards patients treating the environment as a place where they are cared for rather than 'treated' is to be promoted.

Areas for improvement

There was little evidence of formal activity programmes. Activity planning appears to be ad hoc, depending more on the availability of staff and the patient mix rather than a set daily plan of varied therapeutic activities.

The implications of this approach are wide ranging. At the very least, the provision of therapeutic activities will be seen as a low priority and thus stimulation of patients is then not seen as important. At worst, it could be regarded as a 'chore' for staff so that 'caring' for patients is viewed as pretence – especially by carers and relatives. This in turn could lead to lowering of the regard for the hospital and lowering of self-esteem for patients, and care being seen as routine and custodial.

The logistics of Patient Transport Service (PTS) arrangements to bring patients to the EMI Day Hospital imposes significant restrictions on the length of time available for patients (effectively restricting this to 11.00 to 15.30).

There was no indication that the demands on the PTS were not satisfied – but only in the sense that all the patients who were supposed to turn up, did in fact arrive. However, the fact that the PTS takes a long time to both collect patients and subsequently deliver them home points to either a resource problem or a scheduling problem.

Laundry arrangements are inadequate with a reliance on carers or relatives which results in soiled clothing being left in bedside lockers until they are collected. This causes problems for patients with infrequent visitors or no close relatives in which instance a social worker has to be contacted to make alternative arrangements.

We noted that one patient was hand washing her clothes and leaving them to dry over the bath. Although this may be felt to be an encouragement to self-sufficiency, it nevertheless represents a clear infection control issue.

What processes are in operation to ensure that patients receive consistent quality and choice of food which meet their dietary requirements?

Communal eating is encouraged in an attempt to promote social interaction but patients have the choice of eating in their rooms if this is preferred.

Provision of snacks and out of hours food is good and snacks and drinks are available at frequent intervals during the day.

There is choice and some variety in menu provision but variability is a little limited for Day Hospital patients, as the menu is a fixed weekly one.

Assistance with feeding was observed and seen to be appropriate and although protected meal times are not a formal arrangement, visits from medical and other hospital staff are discouraged during meal times.
Relatives are encouraged to visit to assist at mealtimes if they wish.

Areas for improvement

The approach to nutritional assessment and monitoring was inconsistent and fragmented, for example a 'weight book' is kept separately to patient records. While patient records contained references to nutritional assessment, these were not presented in a consistent manner and it was not clear that a uniform approach to monitoring progress was carried out.

No evidence was found of the use of nutritional assessment tools.

How suitable is the environment of care?

Crug ward has ten beds and a mix of male and female patients. There are a number of single rooms and single sex four-bedded bays none of which have en-suite toilet or washing facilities.

The overall environment appeared clean but a little 'tired' in places with some pieces of furniture and soft furnishings well worn and in need of replacement.

Security on the EMI ward appeared good. Internal doors were unlocked, allowing free access to bedrooms and day / sitting rooms and patients also had access to an enclosed garden.

The main ward door is managed with a combination lock and the ward operates a Locked Door Policy. Patients are provided with the code to exit the ward on request provided no risks to their safety have been assessed.

Areas for improvement

Toilet and bathroom facilities on the ward are limited to two toilets, one of which is in the bathroom. There is one bath and one shower room. The shower room is used for storing commodes and is therefore unusable, unless all equipment is removed. The bath was found to be leaking and had patient clothing drying across the seat. Toilets and bathrooms are not designated specifically for male or female use but are lockable. Further facilities are available in the Day Hospital but on the whole the accommodation appears to be inadequate in terms of maintaining privacy and dignity. In order to respect patients' privacy and dignity, single sex toilets and washing facilities must be provided.

Each bed has curtains, which are used to maintain privacy. However, more consideration needs to be given to ensuring that these are kept fully closed when personal care or treatment is being undertaken.

Staff need to be more aware that privacy may be compromised through conversations relating to sensitive patient specific personal or medical information being overheard.

Storage of equipment presents a problem that has led to unacceptable clutter, especially in the bathroom and shower room on Crug ward.

Unlocked cabinets in the bathrooms contain shampoo and other toiletries, which could present a safety hazard to patients. The ward was asked to rectify this immediately as under the Control of Substances Hazardous to Health (COSHH) Regulations 2002[1], chemicals and dangerous substances must be stored and handled in a way that minimises the risks posed by those substances and which limits people's exposure to them. Whilst we recognise that items such as shampoos and conditioners would not necessarily be classed as a chemical or dangerous substance, we do feel that there is a risk of confused older people potentially ingesting such substances especially if they have a fruit like scent.

Some bedrooms hold a few personal possessions but overall there is a general lack of personalisation. There are limited storage facilities for patients' possessions especially clothing.

Signage was adequate for staff use but would certainly be inadequate for a number of patients – especially those with limited eyesight or the confused patient.

Some of the pictorial signs (such as the toilet) had fallen down and not been replaced.

Complaints leaflets were available on the Rehabilitation (Bannau) Ward but not on Crug ward.

The central heating control is managed externally and on the day we visited the ward was very hot. Staff have no control to be able to adjust the heating locally in line with outside temperatures. It would be unreasonable to say that this, on its own rendered the environment unsuitable but it certainly detracted from the otherwise well lit and clean surroundings. There were several adverse comments from staff on their inability to adjust the temperature in line with the external weather conditions.

The presence of a cat on Crug ward clearly provides a significant emotional benefit to patients but nevertheless potentially represents an infection source or dispersal agent. Cats are not seen as a high infection risk in EMI areas, as long as they are regularly vetted, de-wormed and de-flead and kept from areas such as clinical rooms, sluices and any patients who are known to have an infection. These relevant protocols involved in safely keeping a cat should be reviewed regularly.

[1] The Control of Substances Hazardous to Health Regulations 2002.

Were all appropriate services and individuals (including patients and carers) involved in care and treatment?

Multi disciplinary communication is viewed by staff as extremely positive – especially the formal Wednesday multi disciplinary meetings. Team working within the hospital and with outside departments is believed to be effective with good involvement of social workers, district nurses and community psychiatric nurses.

We were told that an advocacy service is readily available, however there was little to indicate how this service is being utilised.

Areas for improvement

Evidence in patient records to indicate the level of involvement of patients and carers in care planning is inconsistent. We understand that relatives and/or carers are invited to multi-disciplinary meetings but their involvement in decision-making was not clear from the records.

Discharge planning is generally unstructured with no clear discharge plans.

Care planning lacks focus in terms of nutritional and spiritual needs and domestic arrangements, leading to a less than holistic approach to overall care.

Formal systems for assessing and recording capacity and consent were not evident and we noted several entries of 'unable to sign' recorded on assessment sheets that ideally should be agreed with individual patients or their carers. We were told that explanations and consent are noted verbally. This approach needs to be improved and staff urgently need to access appropriate training on issues involving consent and the Mental Capacity Act.

Audio books are available but other resources to support patients with sensory impairment are lacking, seeming to depend on individual staff approaches. This can lead to patients feeling isolated and that staff are either unaware or unconcerned as to patients' needs.

Staff were unaware of the loop system in the hospital meaning that some patients may not be benefiting from having their hearing aids appropriately set. Braille facilities and information in large print are available on request but not immediately to hand. This could impact on patients receiving or understanding information given to them.

Staff handover does not follow any formal process. Thus it is unstructured in that there are no set topic areas to be covered and there is no auditable record of handover since no formal note taking is in evidence.

Protection of Vulnerable Adults (POVA) awareness, systems and processes.
Child Protection (POCA) awareness, systems and processes.
Staffing levels and skill mix.

There did not appear to be any nurse staffing issues on Crug ward although the Rehabilitation ward has a staffing problem that has recently led to the closure of three beds.

Areas for improvement

Awareness of POVA processes is poor and staff do not see Child Protection as an area for which they need to take any responsibility or action. This is despite the fact that children visit the ward.

Gaps in staff development include:

- Awareness of what constitutes mandatory training
- POVA and POCA training
- Poor monitoring of training attendance.

Arrangements for reviewing personal and professional development are weak and we were told that no individual reviews have taken place within the last year.

Ward staff expressed concerns about some perceived gaps in out of hours medical cover and cover for annual leave.

Name badges were not being worn by all staff making it difficult to identify staff members. Bannau Ward displays a board with staff photographs and names, which is something that would be useful for Crug ward to replicate.
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Criminal Records Bureau (CRB) checks have not been carried out for staff that have been in post for a number of years. The CRB checks system needs reviewing to ensure statutory obligations are being fulfilled.

I should be grateful if you would provide an action plan addressing the areas for improvement raised in this letter by Friday, 12 February 2010.

In the interim should you have any queries in relation to the content of this letter please do not hesitate to contact me or Tracey Jenkins on 02920 928854 or email tracey.jenkins@wales.gsi.gov.uk.

I am copying this letter to Vinny Ness at the Regional Office.

Yours sincerely

PETER HIGSON
Chief Executive