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Eich cyf / Your ref
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5 July 2010

Dear David

UNANNOUNCED DIGNITY AND RESPECT VISIT: CEFN COED HOSPITAL

I write to advise you of the outcome and actions arising from the unannounced 'Dignity and Respect' visit made to Cefn Coed hospital on 12 and 13 January 2010 and to thank your staff for their positive and helpful contributions.

Immediately after the visit, our reviewers met with members of staff from your Health Board to give some initial feedback.

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 last 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?

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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

The outcomes of this visit will also be used to inform:

- Our review of the implementation of the Older Peoples National Service Framework (NSF) in Wales
- 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 and action plans produced as a result of the visits will be published on our website.

The visit to Cefn Coed Hospital spanned a 24-hour period over Tuesday 12 and Wednesday, 13 January 2010. 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 Dyffryn ward, a mixed sex assessment ward for elderly dementia patients and Ward One, a continuing care, long stay ward for male patients with dementia who present with challenging behavioural problems.

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

All staff interviewed had a basic understanding of the needs of the patient group in relation to dignity and respect.

The interaction by the nursing staff whilst providing care to the patients was observed as being caring and respectful.

It was observed that patients were addressed by their preferred name, and spoken to in a respectable manner. All patients were observed to be clean, tidy and appropriately dressed and wearing their own clothing, which helps detract from a potential 'institutionalised' approach.

There were several patients who were being nursed in bed on Ward One within various bay areas. It was observed that these were regularly checked and observed and the doors to these bay areas were left open so the patients would not feel isolated.

The curtains around all the patients' beds were clean, of adequate length and moved with ease along the curtain tracks, thus ensuring that patient's dignity was respected when a treatment or intervention was taking place within the bed area.

There is a hospital Chaplancy service, which covered the Church of England and Roman Catholic denominations that is readily available. This involved twice weekly visits to the wards. Ministers of other religions are readily available on request.

There was evidence of activity plans for the patients on both wards and access to the Patient Activity Centre.

Staff on the wards were seen to be proactive in therapeutic activities, e.g. playing dominoes and the availability of daily newspapers. This could be further supported with a refocusing/activities nurse on the wards to further enhance the patients' day.

There was an Occupational Therapist service available for the assessment of patients after a referral had been received from the nursing staff

Areas for Improvement

We noted that patient's personal records did not always note their religion. This could result in their spiritual needs not being fully addressed.

Curtain tracks were in the bathrooms but there were no curtains in place. This could impact on patient's privacy if the door were opened whilst they are washing.

There was no evidence of signage notices being used to indicate when care /treatment was in progress behind pulled curtains.

There was no opaque glass in the door to the single-bedded room on Ward One thus comprising the patient's privacy.

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

On Dyffryn ward communal eating took place in an attempt to promote social interaction.

On Ward One, patients went to the dining room, sat in their specialist chairs in the corridor or remained in the lounge. It was a case of using the most appropriate area to accommodate the patient's needs i.e. the specialist chairs where difficult to move into the dining room.

There is choice and some variety in menu provision. The patients were offered a choice of food from the various menus that were sent up on the food trolley to the ward.

The approach to nutritional assessment and monitoring was consistent on both wards. The patients were weighed regularly and their weight recorded on a weight chart.

Assistance with feeding was observed and seen to be appropriate. The food was well presented and assistance was available and observed for those patients who required it from the nursing staff.

It was observed that the portions of food offered to the patients were given according to their individual appetites. Patients and carers interviewed said the quality of the food provided was reasonable with some meals being more tasty and enjoyable than others. Overall the view was that the dietary needs of patients were met, and that quality of food was acceptable.

The provision of out of hours snacks was readily available and in plentiful supply on both wards.

Appropriate cutlery was available to be used where appropriate and necessary.

Areas for improvement

Protected meal times are a formal arrangement on Dyffryn ward with visits from medical and other hospital staff discouraged during meal times. Protected meal times were attempted on ward One but this was not easy due to various interruptions from medical and other clinical staff visiting the patients at meal times.

How suitable is the environment of care?

Both wards were visibly clean and tidy.

We acknowledge that the Board are in the process of relocating services provided on these wards to new purpose built units. During a feedback meeting with members of the Board after HIW's visit we were assured that some of the concerns we raise in this following section would be greatly reduced as part of the new development.

The first impression on entering both wards was that they were visibly clean but in need of redecorating. We were informed in the feedback meeting that redecoration is to take place soon.

Our reviewers felt the layout of ward One is unsuitable for this client group, however the staff manage to make it as comfortable as possible. There was limited space in the day area, with large pillars in the centre of the room. Due to the need for specialist seating for many of the clients, the room was crowded when all patients were present. Ventilation was poor and there was little outlook.
The staff should be commended for the way that they still manage to make this environment feel welcoming and comfortable for the clients.

Dyffryn ward had a calm and relaxed atmosphere and staff and patients were undertaking activities. This ward consists of both male and female patients and the sleeping areas are well defined, with two separate 4-bedded units and a single room to provide some flexibility.

There was evidence of a wide range of hospital clothing available if and when necessary, which was observed to be clean and stain free.

Some relatives took patient's used/soiled clothing home to wash and there was a laundry service available on the hospital site for those patients who had no frequent visitors.

Areas for improvement

Understanding that both wards are to be relocated within the next 1-2 years it is clear that major refurbishment would not be economical at this time. However, we feel the following issues are of concern and improvements need to be made.

As mentioned before, curtain tracks were in the bathrooms but there were no curtains in place. This could impact on patient's privacy if the door were opened.

On Dyffryn our reviewers saw ward one bathroom as being totally unsuitable for this client group as it has a traditional bath up against a wall, which presents serious manual handling issues. On our visit we were informed that this bath is not used and we therefore wonder if it would be more practical if this space were transformed into a wet room.

The second bathroom on Dyffryn ward has a very old, 'high low' bath, which is in a bad state and need of repair.

One of the bathrooms on ward One is used for storage as the bath cannot be used. It is inappropriate for bathrooms to be used as storage areas. If the bathroom is no longer needed, the bath and toilet should be removed and the room should be identified for one purpose.

The second bathroom on ward One also has a high low bath that due to its age has no enamel left in certain areas. There is also a sit-in shower unit in this room, which requires replacing due to cracks and broken areas that could potentially present an infection control risk. It was understood that the Board had looked into purchasing new baths, which could then be transferred to the new unit (within the next eighteen months) when it eventually opens; but we were told that the cost of transferring them would be prohibitive so the Board had rejected this proposal.

The bed areas on both Dyffryn ward and ward One lacked personalisation although it was noted that there was some personalisation on ward one.

The wardrobes on Dyffryn ward were old and did not provide any locked space for patient's personal items or toiletries. The wardrobes on ward One provided a 'hidden' section that was disguised by a mirror frontage for toiletries. 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.

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

Also, the risk issues to patients should be reviewed in particular regard to razors that were kept within unlocked cabinets.

The current beds are outdated and although specialist mattresses can be obtained, the client group would benefit from the 'profiling' style bed with integral cot sides and specialist mattress. We have been informed that it is the intention to have these beds on the new unit.

The living room on ward One appeared very crowded. There were several specialist-seating chairs required by this patient group, which were large and cumbersome. It was accepted that this could be difficult to resolve but it is hoped that planning for the new unit has taken into account the needs of this client group and the amount of space specialist seating requires.

The television on Dyffryn ward is dated and was positioned at the end of the lounge so not all patients could see it. The position of the television should be reviewed so all patients have access to it if required.

Dyffryn ward has been without a washing machine for a few months. Consideration should be given to its replacement. We were told that this machine would be used daily for washing the mesh pants which secure incontinent pads. It was understood these pants were now being thrown away.

Signage needs to be reviewed which should include the use of diagrams and directional indicators. This would assist the patients in the promotion of independence in their daily living activities. .

The provision of hand gel should be reviewed and action taken in line with last years NLPSA guidance advising that the placement of alcohol hand-gel dispensers should be focused within the immediate area that a patient is treated e.g. at the bedside and in clinical areas. There is a need for local risk assessments to take place to determine where hand-gel dispensers should be placed that takes into account the risks associated to individual patients.

There was no visible clutter on Dyffryn ward but there did seem to be an inappropriate amount of clutter in the corridor of ward One e.g. hoists. This was due to the lack of adequate storage space within the ward area.

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

The standard of note keeping was very high on both wards and it was easy to access information from files, which were maintained in good order. Our reviewers felt this was an area of practice worth sharing.

This mental health service group have devised their own patient care planning system which although very different from that used elsewhere in Wales, does define clear individualised care plans very well with a systematic review of patient's needs.

All the records we viewed were up to-date with valid entries i.e. the detail of patient care delivery and reviews of care needs.

It was obvious that regular multi-disciplinary team meetings were taking place. Although clear records of attendees were not recorded, the content of these meetings was recorded in the patient's records. It was difficult from these records to clearly identify carer involvement. However, from interviews with carers it was evident that they feel fully included in the care and decision-making in regards to their relative.

The service does not use Unified Assessment (U.A.) documentation, nor does it use the Care Programme Approach (CPA) which is contrary to National Policy. However, this does not detract from the quality of care planning and assessing which was very good. We also noted the positive way in which the team use the matrix from Continuing Care Assessments in a Multi-disciplinary way.

Communication within both wards is a strong point with all staff showing regard and respect for the patients, each other and visitors.

Areas for improvement

The recording of a patient's mental capacity was inconsistent in the records we reviewed. We were informed that explanations to patients and seeking their consent were noted verbally with no formal system for assessing and recording capacity and consent. The organisation should consider adopting its own form and implementing it so that there is a consistent recognised approach to recording consent and patients' mental health capacity. Staff should also be given the opportunity to access appropriate training on issues involving consent and the Mental Capacity Act.

Fundamentals of Care (FoC) audits were undertaken, however there is a need for the outcomes of these to be disseminated throughout all grades of staff. Feedback has been provided to clinical leads but there needs to be a system to get information to all staff members.

There was no evidence that patients were being assessed for continence. A continence assessment tool needs to be implemented by the service and appropriate training given to accompany its implementation.

When carers are involved in decision-making, efforts should be make to obtain a signature in the patient's notes to evidence this.

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

There was consistency on both wards with regards to children visiting patients. They were not allowed onto the main ward area but provision was made for them to use the visitors or dining room areas and always to be accompanied by an adult.

There was a consistent uptake of mandatory training by nursing staff.

Areas for improvement

The staffing levels and skill mix on ward One was reported by the ward manager as inadequate to care for twenty continuing care patients some of whom were confined to bed. On average there were four staff on each day shift. This was in comparison to five staff on morning shift and four on the afternoon shift on Dyffryn assessment ward with only nine patients.

The staffing skill mix and levels on this ward need reviewing to be adequate according to the patient numbers and needs.

It was evident from the staff interviews that there are deficits in the knowledge and training for Consent, Capacity, POVA and POCA from Band 6 downwards. The difference in the level of knowledge and training between the manager and other staff is noticeable. This should be rectified and the organisation needs to provide a clear route for completing training requirements and the dissemination of information to all grades of staff.

It was apparent that POCA requirements were not seen as relevant due to the wards providing care for adults only.

Not all staff had recent CRB checks; this seems to be focused only at new employees or when a change of contract occurs. We understand that this is an issue for all organisations but it does need addressing.

The lack of staff appraisals needs to be addressed in order to facilitate the implementation of the Knowledge and Skills Framework.

I should be grateful if you would provide an action plan addressing the areas for improvement raised in this letter by Wednesday, 21 July 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 928913 or email tracey.jenkins@wales.gsi.gov.uk

I am copying this letter to Richard Bowen and Marion Andrews Evans.

Yours sincerely

Peter

PETER HIGSON
Chief Executive