Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

# Aneurin Bevan Health Board

## Unannounced Dignity and Essential Care Inspection

## Date of inspection: 1 and 2 February 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 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. 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 2010[2].

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 Appendix A 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.

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[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 1 and 2 February 2012, HIW undertook an unannounced Dignity and Essential Care Inspection at Royal Gwent Hospital.

## Royal Gwent Hospital

1.6 The Royal Gwent Hospital is a district general hospital based in Newport, South Wales. The hospital provides a range of services for inpatients, day case surgery and outpatients.

1.7 As part of our inspection in February 2012 we visited two wards: Ward B3 which specialises in care of the elderly and Ward B6 which specialises in stroke rehabilitation.

# 2. Findings

2.1 This chapter sets out the findings from our visit.

## Ward B3 Care of the Elderly

2.2 Overall the ward appeared calm on the day of our visit and was in the process of *'Transforming Care'* which is a ward-based improvement programme used across NHS Wales that empowers ward teams to improve the quality and efficiency of the services they provide. However, there was a low number of staff on duty on the night shift given the dependency of patients.

### Ward Environment

2.3 The ward was visibly clean and tidy. All the patients we spoke to said they were satisfied with the cleanliness of the ward with five of the seven patients strongly agreeing the ward was clean. The majority of patients agreed that the ward was tidy and everything was in good working order, however one patient disagreed with this statement.

2.4 We were pleased to see toilets and bathrooms clearly marked *'male and female'* with signs that could be easily adjusted for either gender.

2.5 There was a dayroom available on the ward and a relatives/quiet room; however the dayroom didn't seem to be used by patients. When speaking to patients some of them told us that they unaware that the day room had a television and a number of them said that they missed television.

2.6 We observed curtains being pulled around beds when care and treatment was taking place, however there were no signs placed on curtains to inform others that care and treatment was taking place behind closed curtains. We were informed that

signs had been ordered and they were delivered to the ward on the morning of our visit.

2.7 We identified a number of issues in relation to the ward environment which we considered to impact on patient dignity and comfort, specifically:

- The doors to toilets and bathrooms were heavy which resulted in some patients having to leave the door open when using the facilities as they were so heavy to open.
- On the afternoon of our visit, the sun was shining through some of the top windows in a four bedded bay (D) at the end of the ward. These top windows didn't have any curtains or blinds resulting in the sun shining straight into two patients' eyes causing them to become hot and uncomfortable.
- There was tape around some of the windows in the same bay and we were informed by staff that this had been done to reduce the draft which came through the windows. During feedback with the Health Board we were told that a window replacement programme is in place.

## Staff Attitude, Behaviour and Ability to Carry Out Dignified Care

2.8 We witnessed staff being kind, caring and courteous to patients.

2.9 The patients and relatives we spoke to all stated staff were polite and respectful, and patients said staff were kind and sensitive to them when carrying out their care and treatment. However, two patients we spoke to informed us that staff on the ward had not talked to them about their condition or helped them to understand it and also that they had not been involved in making decisions about their care and treatment.

2.10 During the late shift there was a low number of staff for the dependency of patients.

2.11 We didn't observe nurses wearing name badges on the day of our visit making it hard for patients and relatives to identify them.

## Care Planning and Provision

2.12 We considered there to be little evidence of care planning and individualised care, for example:

- We saw no evidence of a formal system or process to gather and record information which could be used to provide person centred care and help the patient regain independence/some form of normality.
- We couldn't find any record of patients' preferred language.
- We noticed that some assessments were incomplete. For example we saw two patients with a risk score of *'5'* for falls which would indicate the need for further assessment, however there was no evidence to show that a further assessment had taken place, the outcomes of which should be fed into the patients' care plan.

2.13 One patient on the ward was *'nil by mouth'* and her notes showed that she hadn't had any fluid intake for the past four days. This patient was immobile and bedbound. It was not clear from the documentation available whether this was an agreed part of the patient's care plan as palliative care[3] was mentioned in the notes but no End of Life Care Pathway was in place. We were therefore concerned that the patient was being treated for End of Life without an appropriate care plan being in place and this was confirmed by a nurse at the time of our inspection. We asked the Health Board to provide us with immediate assurance that this patient was receiving the most appropriate care for her needs. They responded very quickly and informed us that prior to our visit the patient had been reviewed regularly by the Senior Medical team and subcutaneous fluids were commenced for a short period. Following our visit the End of Life Pathway had been commenced and the patient's family had been engaged in the discussions regarding End of Life.

[3] Therapy designed to relieve or reduce intensity of uncomfortable symptoms but not to produce a cure.

2.14 This particular patient was also wearing incontinence pads and we felt a catheter may have been a more appropriate for a patient in her condition. Again we asked the Health Board to provide us further information about the appropriateness of catheterising this patient. The Health Board informed us that:

> '*Consideration has been given to the insertion of a urinary catheter but has not been inserted. The Catheter Associated Urinary Tract Infections bundle was considered and we only catheterize after careful consideration given the infection control risk. A regular medical review plan has been put into place and all nursing care and documentation has been reviewed and is being monitored daily.'*

2.15 Another patient on the same ward had at the time of our visit been in bed for four weeks. This patient's notes stated that she could be hoisted out of bed and her relatives told us that they were concerned that the patient may become bedbound due to her being in bed all the time. This patient's notes stated that she was *'not for rehabilitation'* and was *'bedbound,'* but speaking to her relatives it became apparent that this clearly had not been communicated to them.

2.16 We asked the Health Board to provide us with immediate assurance that they review this particular patient's care plan and ensure that her best interests are at the centre of her care and that her relatives are fully involved in this process (if this involvement is also in the patient's best interests). The Health Board wrote to us following our visit and advised that:

> '*A discussion with both the patient and their family had taken place and had resulted in the patient being assisted to sit out of bed and in a chair for short periods. This had taken place on a number of occasions and in the presence of family members. The patient's care plan had been reviewed and the patient's relatives have been included in this process.'*

## Records Management

2.17 There were inconsistencies in patient notes as some care and treatment was documented and some was not, one patient's charts showed that she hadn't been washed on the day of our visit; however staff assured us that she had been. It is important for both the patient and the staff that notes provide clear evidence of the care delivered.

2.18 There was a lack of evidence to show that fluid charts were always being updated by staff. We also found that input and output charts detailing food, fluid and bowel/bladder movements were inconsistently being completed.

## Fluid and Nutrition

2.19 During our visit we observed a mealtime. We noted that prior to patients being given their meals there was a little assistance provided by staff to help prepare patients for their lunch. For example when their meals were delivered to their bed some patients were not sitting up in bed properly making it difficult for them to reach and eat their food.

2.20 We also saw no evidence of patients being offered support to wash their hands before or after meals and patients told us that this didn't happen.

2.21 There was a traffic light system in place on the ward which helped ward staff to identify who needed assistance with eating. However, at the time of our visit, patients were not getting the assistance they needed in a timely manner.

2.22 A number of patients commented that the food was cold and on the day of our inspection we were told that the food was *'hard'* to eat because it was cold (battered fish).

2.23 We witnessed a ward clerk assisting one patient to eat his meal; whilst we understand that she was assisting so that the patient got to eat his food whilst it was still hot, this particular patient was on a *'red'* traffic light and on thickened fluids

meaning he was at risk of aspiration. Therefore it would have been more appropriate for this patient to be assisted by a member of nursing staff as this assistance is both dangerous for the patient and the ward clerk.

2.24 We witnessed one healthcare support worker give two patients a hot drink, however she placed them out of their reach which resulted in one patient spilling his drink when trying to reach it.

### Pressure Sores

2.25 There were two patients on the ward who were at risk of pressure sores and hence should have been having a *'Waterlow'*[4] assessment completed every two days, however their records highlighted that they hadn't had assessments for seven and nine days respectively. This issue was raised immediately with the Health Board who has advised us that since our visit:

> *'All risk assessments have been reviewed and updated and are being closely monitored. These include the Waterlow risk assessments for the patients identified.'*

The Health Board confirmed that the two patients in question were reviewed accordingly but the outcome of the review determined that they required no additional actions or interventions at this time.

### Personal Care and Hygiene

2.26 The majority of patients were wearing clean clothes; however we observed food stains on some patients' clothing.

[4] The *'Waterlow'* is a pressure ulcer risk assessment/prevention policy tool.

2.27 As referred to in paragraph 2.17, records showed that one very ill patient had not been washed on the day of our visit, we raised this with staff at the time and were informed that this had actually happened but it hadn't been written up in the patient's notes.

2.28 We spoke to the relative of one patient who informed us that her mother hadn't had her hair washed during the four weeks that she had been on the ward. During staff interviews we were informed that owing to manual handling risk assessments it was not possible for them to assist patients to get into the bath. We addressed this issue with the ward manager who told us that patients would have a dry hair wash whilst in bed. However, we find it unacceptable that some patients on the ward were not routinely having their hair washed.

2.29 Several of the patients on the ward were in their night clothes at the time of our visit. We were informed by the ward manager that she tries to encourage patients to wear their day clothes. We recognise that it's important for patients to feel comfortable during their hospital stay but at the same time it is also important for the Health Board to reduce the sense of institutionalisation.

### Toilet Needs

2.30 We were on the ward for over six hours, yet during this time we saw very few patients being assisted to use or using the toilets. We also didn't observe many patients being given a commode and only witnessed one bedpan being used. In addition, during the feedback meeting we were informed that only a small number of patients were catheterised.

2.31 Of the number of patients who were catheterized on the day of our visit we observed that some of these catheters were somewhat full at the time of our inspection. For example one patient had two and a half litres of urine in her catheter bag and a note had been written in her records the day before our visit asking for her catheter bag to be emptied regularly, however this hadn't happened.

## Buzzers

2.32 All patients had buzzers/call bells in reach and these were being answered in a timely manner.

## Medicines and Pain Management

2.33 None of the patients we spoke to highlighted pain management as an issue for them.

2.34 We were pleased to see that the nurses carrying out medication rounds were wearing red tabards with *'Do Not Disturb'* on them. However during the round we observed a patient asking to go to the toilet and both nurses carrying out the round took the patient to the toilet and left tablets on the patient's bedside table and left the drug trolley open.

2.35 We also identified that nurses weren't waiting to check that medication was being taken. We witnessed one patient drop their medication on the floor and this could have gone under the bed and been recorded as though it had been taken. Our reviewer informed a member of staff at the time.

## Discharge Planning

2.36 There was evidence of discharge planning in patient notes; however a number of patients we spoke to weren't aware of when they might be leaving the ward or where they would be going. This is concerning as it demonstrates that discharge planning was not being 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.

### Activities

2.37 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. Research [5] has shown that activities on hospital wards have a range of positive effects on inpatients, including:

- Inducing positive physiological and psychological changes in clinical outcomes.
- Reducing drug consumption.
- Shortening length of hospital stay.
- Promoting better doctor-patient relationships.
- Improving mental health.

2.38 Other than some evidence of paper and magazines and televisions in the bay areas there were no stimulating activities on the ward and the patients we spoke to commented on the lack of such activities.

2.39 There was a television in the dayroom; however we were unable to get it to work. We found that the dayroom was unused and when speaking to patients some of them told us that they didn't know it existed.

## B6 Ward (Stroke Rehabilitation)

2.40 We observed a high quality of care being provided by staff despite the high dependency of the patients.

[5] British Medical Association, *'The psychological and social needs of patients,'* January 2011.

## Ward Environment

2.41 There was a large amount of clutter throughout the ward for example: a quarter of the dayroom was being used to store items such as tables, chairs, medical equipment and gas cylinders. We were informed by staff that the ward was being moved to another location within the hospital in April; however the state of the ward at the time of our visit was not conducive to delivering effective patient care as clutter prevents effective cleaning from taking place and also presents infection control risks on the ward.

2.42 We were pleased to see that all bathrooms were designated male and female; however there was only one bath and one shower at either end of the ward which meant that patients needing to use either facility would have to walk a long distance. Due to the health of some of the patients on the ward this was an issue.

2.43 We observed curtains being pulled around beds when care and treatment was taking place, however there were no signs placed on curtains to inform others that care and treatment was being provided behind the closed curtains.

## Staff Attitude/Behaviour/Ability to Carry Out Dignified Care

2.44 Staff on the ward were caring and kind towards patients.

2.45 The patients that we spoke to told us that staff were polite to them, kind and sensitive when carrying out care and treatment. We were also informed by the patients that we spoke to that the staff on the ward listened to them, their friends and family.

2.46 During our time on the ward we observed nurses attending to patients' needs in a dignified manner. However during a medical round we observed a doctor talking to patients in a four bedded bay in a loud manner. For example, the doctor was discussing one patient's anti-depressant medication, which was not appropriate as it was not maintaining the patient's privacy and dignity.

2.47 Overall we felt that the high dependency for patients on the ward was too high for the current staffing levels. During our inspection visit, Ward B6 had a ratio of eight patients to one registered nurse on a 12 hour shift.

2.48 We didn't observe nurses wearing name badges on the day of our visit making it hard for patients and relatives to identify them.

### Care Planning and Provision

2.49 There were very few individualised patient care plans, the care plans we reviewed were generic. Individual care plans should be available for all stroke rehabilitation patients as individualised care is essential given the varying symptoms/problems that they have to overcome.

2.50 A *'records of care'* assessment tool was being used on the ward to collate patient assessments. However the patient assessments contained within this assessment tool were poor. Out of 24 patients on the ward:

- Only eight had up to date Waterlow Risk Assessments.
- Only ten had a patient handling risk assessment.
- Only four had a completed falls assessment.

### Records Management

2.51 There was evidence of patient *'personal care records'* within medical notes; however we identified that these records were not always completed.

### Fluid and Nutrition

2.52 There was a dayroom available where patients could sit at a table to eat their meal, however all the patients on the ward ate their meals in or next to their bed.

2.53 We did not observe patients being offered hand washing facilities before meal times on the ward.

2.54 There was a traffic light system in place on the ward which helped ward staff to identify who needed assistance with eating and we observed patients being appropriately assisted at meal time.

2.55 We also observed patients being assisted to drink by staff on the ward. Water jugs were present on patient bedside tables but we observed that a number of patient cups were empty or nearly empty. We also identified that the water was not always in reach of the patient which may make it difficult for some individuals.

2.56 Food and fluid charts were available on the ward; however these were not always completed after meals/fluids being consumed. We were informed by staff that they do not always have the time to remember to complete the charts.

### Pressure Sores

2.57 All patients who were unable to get out of bed were on *'pressure mattresses'* to limit the development of pressure sores[6].

2.58 All patients who are not fully mobile should have a *'Waterlow'* risk assessment to assess the risk of a patient suffering from pressure damage. However, only eight patients on the ward had an up to date *'Waterlow'* Risk Assessment.

2.59 Staff knowledge around pressure sores was good and we observed patients at risk of pressure sores being turned every two-three hours. However, there was limited documentation in patient notes to evidence that this care had been provided.

### Personal Care and Hygiene

2.60 A small number of patients on the ward were wearing dignity gowns as opposed to their own clothing. We were informed by staff that this was due to the patients' condition and it was easier for the patient and staff for them to remain in gowns.

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[6] Pressure sores or pressure ulcers develop when sustained pressure is placed on a particular part of the body and interrupts the blood supply to that part of the body.

2.61 It was noted that staff were helping those patients who needed assistance to wash, however there was a lack of documentation to evidence this. There was also no evidence of patients having had their hair washed since they were admitted to the ward.

### Toilet Needs

2.62 Patients were able to use a variety of toileting methods; we observed staff assisting patients to and from the toilet and patients being provided with a commode.

### Buzzers

2.63 We observed that not all patients had access to buzzers/call bells at the bedside. We asked the Health Board to provide us with immediate assurance that this issue would be rectified and they told us since our visit:

> *'Access to buzzers/call bells has been reviewed throughout the ward and during this time two buzzers were identified as malfunctioning.'*

These were addressed immediately as surplus call bells were available on the ward. The review of call bells form part of the daily checks undertaken on the ward.

### Medication and Pain Management

2.64 We observed staff talking to patients about their medication and medication was recorded once it had been administered. Also, none of the patients we spoke to on the ward raised any concerns regarding pain management. However not all patients on the ward had an up to date pain score (measurement of pain intensity) available.

2.65 We observed two occasions when staff left medication on patient bedside lockers.

## Discharge Planning

2.66 As with Ward B3, we spoke to a number of patients and not all of them were aware of what was planned for them in terms of being discharged from the ward.

## Activities

2.67 There was a dayroom available with a television; the room also included a few books and jigsaws. However, as previously mentioned a quarter of the room was taken up by clinical clutter.

2.68 The patients we spoke to on the ward informed us that there were no stimulating activities for patients on the ward. We were also informed that there was no newspaper round. The newspapers on the ward were being brought in by relatives.

# 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 ensure that measures are put in place across the Health Board to inform others of care and treatment taking place behind closed curtains.

3.4 The Health Board should provide HIW with assurance that it has reviewed the use of heavy bathroom/toilet doors and the lack of blinds on the high windows on Ward B3 and has a plan to address these issues.

3.5 The Health Board should inform HIW of its timetable for its '*Window Replacement Scheme.'*

## Staff Attitude and Ability to Carry Out Dignified Care

3.6 The Health Board should review its current staffing levels to ensure that patient care is not regularly compromised due to short staffing.

3.7 The Health Board should remind all Health Care Support Workers of the importance of putting drinks within reach of patients.

3.8 The Health Board should ensure that all staff on the wards are wearing identification badges whilst on duty.

3.9 The Health Board should ensure that staff who carry out medical rounds do so in a sensitive manner to maintain patient privacy and dignity.

3.10 The Health Board should ensure that all staff are aware that patients are fully informed and involved in discussions about their condition and treatment.

## Care Planning and Provision

3.11 The Health Board should ensure that all in-patients have care plans which are adapted to specific patients needs based on the outcomes of all relevant assessments and that these care plans are regularly reviewed and updated.

3.12 The Health Board should ensure that all patient assessments are fully completed and documented and further assessments are undertaken where needed i.e. risk of falls.

3.13 The Health Board should ensure that the patient's preferred language is documented in their care plan.

3.14 The Health Board should ensure that where appropriate, relatives are fully informed and involved in discussions about a patient's condition.

3.15 The Health Board should ensure that a system or process is in place to capture the *'patient story/information.'*

3.16 The Health Board should ensure that patients requiring end of life care are recognised and put on an end of life care pathway at the appropriate time.

3.17 The Health Board should ensure that all patients who can be mobilised out of bed are encouraged and supported to do so.

### Fluid and Nutrition

3.18 The Health Board should ensure that all patients are positioned appropriately before meal times to ensure that they are able to eat their food in a comfortable position.

3.19 The Health Board should ensure that patients are provided with the opportunity to wash their hands before meal times.

3.20 The Health Board should ensure that patients who require assistance to eat during meal times are provided with that assistance by an appropriate member of staff in a timely manner.

3.21 The Health Board should ensure that all food provided to patients on wards is at an appropriate temperature.

3.22 The Health Board should ensure that all patients are routinely provided with fresh water throughout the day which is easily accessible to them.

### Pressure Sores

3.23 The Health Board should ensure that all patients at risk of pressure sores receive the necessary risk assessment and these assessments are kept up to date.

### Personal Care and Hygiene

3.24 The Health Board should ensure that all personal care and hygiene provided to patients is documented.

3.25 The Health Board should ensure that patients who need assistance are regularly offered and assisted to have their hair washed and this is documented in the patients' notes.

3.26 The Health Board should ensure that it is in the best interest of the patient for them to remain in their night clothes or dignity gowns throughout the day and this is documented in their notes.

### Toilet Needs

3.27 The Health Board should ensure that catheter bags are regularly emptied.

3.28 The Health Board should ensure that patients are encouraged and supported to use the toilet method of their choice.

### Buzzers

3.29 The Health Board should ensure that all patients on wards have access to a fully functional buzzer at all times.

### Medication and Pain Management

3.30 The Health Board should ensure that methods are in place to ensure that patients take their medication when it is administered and therefore not left unattended on patient bedside cabinets.

3.31 The Health Board should ensure that drug trolleys are not left unlocked and unattended.

3.32 The Health Board should 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.

### Records Management

3.33 The Health Board should ensure that all care and treatment provided to patients is routinely documented in the patients' notes.

3.34 The Health Board should ensure that patient input/output charts (including food and fluid) are fully completed and monitored by staff on wards.

### Discharge Planning

3.35 The Health Board should ensure that patients and where appropriate their relatives are fully involved and informed in the discharge planning process.

## Activities

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

3.37 The Health Board should ensure that patients are informed, encouraged and supported to use the day room facilities on wards.

3.38 The Health Board should ensure that the television on Ward B3 is in working order and easy for patients to work.

3.39 The Health Board should ensure that the dayroom on ward B6 is appropriate for patient use.

# 4. Conclusion

4.1 The majority of staff we observed were being kind and caring to patients and patients themselves told us that staff were polite to them and kind and sensitive when carrying out care and treatment.

4.2 During our visit we found a number of other areas for improvement such as:

- The need for more individualised care planning and patient assessments to be completed and up to date.
- Nursing staff to record the care and treatment they provide patients as we found a lack of evidence to show that certain care had been carried out.
- The need for patients to be prepared for meal times as we found there was a lack of hand washing before meals and some patients were not positioned in their beds appropriately to eat their meal.

## 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 issue we identified on the two wards 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 Aneurin Bevan Health Board, especially the staff on Wards B3 and B6 who were helpful throughout the inspection.

## Appendix A

# 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 Carry Out 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 are then required to provide HIW with an action plan to address the key issues highlighted.

## Appendix B

## 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.

## 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** |
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| **Ward Environment** | Right to liberty and security (Article 5).<br><br>Right not to be tortured or treated in an inhuman or degrading way (Article 3).<br><br>Right to respect for private and family life (Article 8). | **12. Environment**<br><br>Organisations and services comply with legislation and guidance to provide environments that are:<br><br>d) safe and secure;<br>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).<br><br>Right not to be discriminated against (Article 14). | **2. Equality, Diversity and Human Rights**<br><br>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:<br><br>a) needs of individuals whatever their identity and background, and uphold their human rights. |

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| | | **10. Dignity and Respect**<br><br>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.<br><br>**26. Workforce Training and Organisational Development**<br><br>Organisations and services ensure that their workforce is provided with appropriate support to enable them to:<br><br>a) maintain and develop competencies in order to be developed to their full potential;<br>b) participate in induction and mandatory training programmes;<br>c) have an annual personal appraisal and a personal development plan enabling them to develop their role;<br>d) demonstrate continuing professional and occupational development; and<br>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).<br><br>Right to liberty and security (Article 5).<br><br>Right not to be discriminated against (Article 14). | **2. Equality, Diversity and Human Rights**<br><br>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:<br><br>a) needs of individuals whatever their identity and background, and uphold their human rights.<br><br>**8. Care Planning and Provision**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>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. |

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| **Care Planning and Provision** | Right not to be tortured or treated in an inhuman or degrading way (Article 3).<br><br>Right to liberty and security (Article 5).<br><br>Right not to be discriminated against (Article 14).<br><br>Right to freedom of expression (Article 10). | **7. Safe and Clinically Effective Care**<br><br>Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care:<br><br>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;<br>b) that complies with safety and clinical directives in a timely way; and<br>c) which is demonstrated by procedures for recording and auditing compliance with and variance from any of the above.<br><br>**8. Care Planning and Provision**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>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;<br>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. |

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| **Communication** | Right to freedom of expression (Article 10).<br><br>Right not to be discriminated against (Article 14).<br><br>Right not to be tortured or treated in an inhuman or degrading way (Article 3).<br><br>Right to respect for private and family life (Article 8). | **2. Equality, Diversity and Human Rights**<br><br>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:<br><br>a) needs of individuals whatever their identity and background, and uphold their human rights.<br><br>**9. Patient Information and Consent**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>a) providing timely and accessible information on their condition, care, medication, treatment and support arrangements;<br>b) providing opportunities to discuss and agree options;<br>c) treating their information confidentially;<br>d) obtaining informed consent, in line with best practice guidance; and<br>e) assessing and caring for them in line with the Mental Capacity Act 2005 when appropriate.<br><br>**18. Communicating Effectively**<br><br>Organisations and services comply with legislation and guidance to ensure effective, accessible, appropriate and timely communication and information sharing:<br><br>b) with patients, service users, carers and staff using a range of media and formats;<br>c) about patients, service users and their carers;<br>e) addressing all language and communication needs. |

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| **Fluid & Nutrition** | Right not to be tortured or treated in an inhuman or degrading way (Article 3). | **14. Nutrition**<br><br>Organisations and services will comply with legislation and guidance to ensure that:<br><br>a) patients' and service users' individual nutritional and fluid needs are assessed, recorded and addressed;<br>b) any necessary support with eating, drinking or feeding and swallowing is identified and provided;<br><br>where food and drink are provided:<br><br>d) a choice of food is offered, which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all; and<br>e) is accessible 24 hours a day. |
| **Pressure Sores** | Right not to be tortured or treated in an inhuman or degrading way (Article 3). | **8. Care Planning and Provision**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>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**<br><br>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:<br><br>a) needs of individuals whatever their identity and background, and uphold their human rights. |

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| | | **10. Dignity and Respect.**<br><br>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.<br><br>**8. Care Planning and Provision**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>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;<br>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**<br><br>Organisations and services have equality priorities in accordance with legislation which ensure that they recognise and address the:<br><br>a) needs of individuals whatever their identity and background, and uphold their human rights.<br><br>**8. Care Planning and Provision**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>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;<br>b) providing support to develop competence in self-care and promote rehabilitation and re-enablement. |

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| | | **10. Dignity and Respect**<br><br>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).<br><br>Right to liberty and security (Article 5). | **7. Safe and Clinically Effective Care**<br><br>Organisations and services will ensure that patients and service users are provided with safe, effective treatment and care:<br><br>b) that complies with safety and clinical directives in a timely way.<br><br>**8. Care Planning and Provision**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>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**<br><br>Organisations and services recognise and address the needs of patients, service users and their carers by:<br><br>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. |

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| | | **15. Medicines Management**<br><br>Organisations and services will ensure that:<br><br>a) they comply with legislation, licensing and good practice guidance for all aspects of medicines management including controlled drugs;<br>b) clinicians are qualified and trained in prescribing, dispensing and administering medicines within their individual scope of practice; and<br>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**<br><br>Organisations and services manage all records in accordance with legislation and guidance to ensure that they are:<br><br>a) designed, prepared, reviewed and accessible to meet the required needs;<br>b) stored safely, maintained securely, are retrievable in a timely manner and disposed of appropriately;<br>c) accurate, complete, understandable and contemporaneous in accordance with professional standards and guidance; and<br>d) shared as appropriate. |

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