Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Betsi Cadwaladr University Health Board

Unannounced Dignity and Essential Care Inspection

Date of inspection: 14 and 15 December 2011

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In writing:

Communications and Facilities Manager
Healthcare Inspectorate Wales
Bevan House
Caerphilly Business Park
Van Road
CAERPHILLY
CF83 3ED

Or via

Phone: 029 20 928850
Email: hiw@wales.gsi.gov.uk
Fax: 029 20 928877
Website: www.hiw.org.uk

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Contents

1. Introduction

1.1 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. 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 14 and 15 December 2011, HIW undertook an unannounced Dignity and Essential Care visit to Ysbyty Glan Clwyd Hospital.

Ysbyty Glan Clwyd Hospital

1.6 Ysbyty Glan Clwyd, part of Betsi Cadwaladr University Health Board, is the district hospital for the central area of North Wales. The hospital is situated in Bodelwyddan, 4 miles south of Rhyl, and serves a population of approximately 195,000. Ysbyty Glan Clwyd provides a range of medical services.

1.7 As part of the inspection we undertook in December 2011 we visited two wards: Ward 1 which specialises in care of the elderly and Ward 11 which specialises in gastroenterology and care of the elderly.

2. Findings

2.1 This chapter sets out the findings from our visit.

Ward 1 (Care of the elderly)

2.2 Overall we found that the ward had a calm and relaxed atmosphere that was conducive to the wellbeing of patients. The ward staff we met had an appetite for change and were clearly engaged in the process of 'Transforming Care[3].'

Ward environment

2.3 The ward was visibly clean and well maintained and the patients we spoke to said they were satisfied with the cleanliness of the ward. However, we identified a number of issues in relation to the ward environment which we considered to impact on patient dignity and respect:

- A shower / washroom on the ward was being used by both male and female patients, and we considered this not to be conducive to maintaining patients privacy and dignity.
- There was a 'bathroom' sign inappropriately placed on the education room door which could be confusing for patients on the ward.
- We observed that signs were not in use to inform others that care and treatment was taking place behind closed curtains.
- We found that there was no dedicated space where relatives of patients could be spoken to in private.

[3] 'Transforming Care' is a ward-based improvement programme across NHS Wales that empowers ward teams to improve the quality and efficiency of the services they provide.

Staff attitude, behaviour and ability to carry out dignified care

2.4 We observed staff providing care in a sensitive manner. There was a positive attitude towards providing dignified care and in recognition of the importance of this area, targets had been set.

2.5 The ward has a 'Caring Champion of the Month' initiative, where patients, staff and relatives can nominate a member of staff for the award. We felt that this initiative was practice worth sharing.

2.6 The patients and relatives we spoke to all stated that staff spoke to them in a polite and respectful way. Patients also informed us that staff on the ward provided assistance to patients that required help eating, drinking and going to the toilet in a sensitive way.

Management of patients with dementia

2.7 We observed staff treating patients with dementia in a very dignified and sensitive manner throughout the day. We also observed patients on the ward with dementia who as part of their condition exhibited exploratory walking behaviour (commonly referred to as 'wandering'). Sometimes patients who 'wander' on a hospital ward can impact on the privacy and dignity of other patients, for example we witnessed one patient with dementia walk into another patient's cubicle when care and treatment was taking place.

2.8 At the time, we observed staff on the ward deal with this issue very sensitively, by engaging them in conversation and providing them with support.

2.9 Some members of staff we spoke to on this ward and ward 11 raised concerns to us about how to manage patients presenting with challenging behaviour. There was a lack of clarity among staff we spoke to about how to manage this or the appropriate safeguarding and escalation procedures they should follow. For example, we were informed about an incident on the ward when a patient had assaulted two members of staff and a fellow patient. Although the incident was

recorded at the time which detailed that the patient who was assaulted sustained bruising, a Protection of Vulnerable Adults (POVA)[4] referral had not been made as staff considered it inappropriate because the aggressor was another patient.

Care planning and provision

2.10 We found that in general, care for older patients was being provided well, however very limited care planning was evident on the ward. Assessments were being carried out but there was little evidence to show how these assessments shaped a patient's care. This lack of care planning can have a particularly detrimental impact on patients with more complex care needs. Whilst visiting the ward we saw an example of this in relation to a patient whose condition was deteriorating very quickly. We were very concerned that this had not been reflected in the amount of monitoring that the patient was receiving and there also appeared to be a lack of escalation to the appropriate medical staff. We brought this to the attention of the ward manager who took immediate action.

2.11 The communication with this patient's family also appeared poor; in particular, we were concerned that the patient's consultant doctor had documented that the patient was 'not for resuscitation.' however when we spoke to the patient's family, they were not aware of this.

Fluid and nutrition

2.12 We observed healthcare assistants being very attentive to patients at meal times. Patients were also being encouraged by staff to get out of bed to eat their meals to encourage a sense of normality.

[4] **Protection of Vulnerable Adults (PoVA) –** adult protection procedures which give Social Services the responsibility for receiving referrals about and co-ordinating investigations into circumstances where a vulnerable adult has been abused or neglected. The procedures are based on the National Assembly for Wales' publication, in July 2000, *In Safe Hands: Implementing Adult Protection Procedures in Wales* - guidance issued under Section 7 of the Local Authority Social Services Act 1970.

2.13 We were informed by patients that they always have access to fresh water. However, we observed that food and fluid charts were not always being updated by staff which we immediately brought to the attention of the Senior Nurse on the ward.

2.14 Patients were being scored against the Malnutrition Universal Screening Tool ('MUST'[5]) upon admission. However there was no guidance as to what action should be undertaken with regard to the outcome score, nor did it appear that any action plan was put in place as a result. Also it did not appear that the score was being reviewed.

Pressure sores

2.15 There are Health Board targets in place for reducing the amount of pressure sore incidents and there is a system for monitoring progress on the ward.

2.16 Ward staff were aware of the appropriate channels to raise concerns about patients arriving at hospital with pressure sores and there was evidence that they had made POVA referrals about this in the past.

2.17 However, at the time of our visit, we identified three patients who were on pressure relieving mattresses; however these did not appear to match their needs.

Personal care and hygiene

2.18 Patients were dressed in their own clothes and patients who were going home were appropriately dressed. This created a sense of normality and independence on the ward and helped prevent an 'institutional' atmosphere. Patients' general hygiene appeared to be addressed well.

[5] 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese.

2.19 Patients we spoke to stated that they were able to wash and clean their teeth (with or without assistance) as regularly as they wanted to.

2.20 However, we did not observe hand washing being offered to patients prior to meal times.

Toilet needs

2.21 We observed patients being taken to the toilet and being supported to use bedpans. The patients we spoke to who required or had previously required assistance to use the toilet told us that staff gave them a choice as to which method they used and also assisted them in a sensitive way.

2.22 However, one relative of a patient on the ward informed us that she was having to take home six sets of wet pyjamas every two days, which we were concerned suggested a lack of responsiveness to the patients toilet needs. This issue was discussed during feedback with the Health Board at the end of our visit and we received assurances that this would be looked into and addressed immediately.

Buzzers

2.23 Patients had access to buzzers to call for assistance that were appropriately placed. While on the ward we observed buzzers being answered in good time and we were informed by the patients that we spoke to that when they use their buzzers, staff come to help them. However, patients also told us that the time it takes for staff to answer buzzers can vary depending on how busy they are.

Medicines and pain management

2.24 The patients we spoke to didn't identify pain management as being an issue for them during their stay on the ward. However observation charts only recorded patient pain scores (measurement of pain intensity); there was little evidence to suggest that these scores were being evaluated.

2.25 We noted that in one patient's notes, 'arthritic pain' had been identified, but there was no evidence of action taken to address this.

2.26 We reviewed the notes of a patient who was on the All Wales Care Pathway for the Last Days of Life[6]. In this patient's notes it was documented several times that this patient had pain / agitation, at which time medication was given or the doctor called. However the notes showed that it had taken 24 hours for a prescribed syringe driver to be put in place. We raised this issue with ward staff on the day of our visit and brought it to the attention of the Health Board during the feedback session.

2.27 This particular issue, along with the incident raised in paragraph 2.10 again suggests that although the routine care of elderly patients on the ward was provided well, staff need further training in relation to the appropriate management of patients with more acute or complex care needs.

Discharge planning

2.28 A system for discharging patients from the ward was in place and a predicted discharge date put on a white board. However at the time of our visit this information was not up to date as some of the dates had passed and the patients were still on the ward. We raised this with the ward manager at the time and were assured that it would be updated immediately.

2.29 Three of the patients we spoke to told us that even though they knew when they were due to leave the ward, they did not know what was going to happen when they left. 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.

[6] The All Wales Care Pathway for the Last Days of Life is intended as a guide in providing care for the patient and their family in the last days of life.

Activities

2.30 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 [7] 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.

2.31 There was a television in every bay on the ward apart from the two-bedded bay where we were informed by one of the patients that it was broken. Staff had been made aware and had attempted to fix the television but as of yet it had not been repaired.

2.32 Other than 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 activity.

2.33 We were disappointed to find that the day room on the ward had been converted into a store room, and a number of patients we spoke to commented on the lack of activities on the ward. The day room would have been a useful resource to enable more patient activities.

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

Ward 11 (Gastroenterology and Care of the elderly)

2.34 Overall the ward appeared busy but well organised and focussed, and staff we met were friendly and helpful.

2.35 However, we were concerned that the patient mix on the ward could be an issue as a significant number of the gastroenterology patients were recovering alcoholics and these patients were sharing the ward with Care of the Elderly patients.

Ward environment

2.36 The ward was tidy and there was ample storage space throughout the ward.

2.37 A number of the rooms on the ward were incorrectly signed, for example there was a 'bathroom' sign on the door which was being used as a store room. We were informed by staff that the room had been used as a store room for a number of years.

2.38 As on Ward 1, we did not observe any signs in place to inform others when care and treatment was being provided behind closed curtains.

Staff attitude, behaviour and ability to carry out dignified care

2.39 We observed staff doing their jobs appropriately and providing care in a sensitive manner. The patients we spoke to on the ward said that staff spoke to them politely and that they felt that staff listened to them.

Management of patients with Dementia

2.40 As mentioned on Ward 1, a member of staff on this ward also raised concerns about challenging behaviour and the staff's knowledge of how to deal with this.

Care planning and provision

2.41 As on Ward 1, there was a lack of evidence of formal care planning. Care and assessments were being undertaken on the day of our visit, however there was no documentary evidence of care being planned, updated or evaluated in any of the patient records we examined.

2.42 We were concerned about one patient on this ward whose condition had deteriorated. The issues we identified here are similar to the lack of appropriate monitoring in response to deterioration in condition on Ward 1.

Fluid and nutrition

2.43 There appeared to be no nutritional care plans in place despite the fact that the ward cared for gastroenterology patients. We also found the use of food charts variable.

2.44 In general, we observed patients who needed assistance to eat at meal times receiving it. However, during the lunchtime period we observed one patient who had not been repositioned appropriately in her bed, hence she struggled to eat. We notified a member of staff at the time who then assisted the patient to reposition herself which meant she was able to eat her meal.

Pressure sores

2.45 We were pleased to see that the ward had won an award last year for the low level of pressure sores.

2.46 'Skin Bundle'[8] care plans were in existence for those patients on the ward identified as being at risk of developing pressure sores. However several of the care plans we examined were not tailored to the patients' individual needs.

[8] 'Skin Bundle' is a simple holistic approach to ensuring that patients receive appropriate care to prevent skin damage.

Personal care and hygiene

2.47 Patients on the ward appeared well cared for in terms of hygiene and personal care. However we had concerns regarding the oral hygiene of two patients who we felt required more attention.

2.48 Dignity gowns were not available on the ward but there was reasonable access to pyjamas.

Toilet needs

2.49 We observed patients being helped to use their preferred method of going to the toilet e.g. using a commode at the bedside or walking to the toilet. The patients we spoke to all stated that they are always asked which method they would like to use and also said that staff assisted them sensitively.

Buzzers

2.50 Patients had access to buzzers to call for assistance and nurses were seen to respond to these in a timely manner.

Medicines and pain management

2.51 None of the patients we spoke to raised any issues with regard to pain management. However, we identified that pain scores are not always completed in patient records making it hard to see how pain is being measured and monitored.

2.52 We were concerned to observe that medicine was left out on one patient's bedside cabinet. We raised this with ward staff at the time and ensured it was removed immediately.

Discharge planning

2.53 We noted that the discharge planning for a patient on the All Wales Care Pathway for the Last Days of Life was good. Even though the patient was still on the ward, there was clear evidence that efforts had been made to discharge the patient to his preferred place of care; however unfortunately this discharge had not occurred due to the patient's condition changing. We found the care of this patient to be of a high standard.

Activities

2.54 There is a day room on the ward which included a television and books. We were also informed that newspapers are available via a volunteer but this is only for two days a week. Other than this, the provision of any stimulating activities was absent on the ward and a number of patients we spoke to commented on the lack of activities.

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 all mixed sex wards have gender specific bathroom facilities available.

3.3 The Health Board should ensure that inappropriate or misleading signage on wards across the Health Board is removed or replaced.

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

3.5 The Health Board should provide an appropriate place for patients and relatives to have private conversations on wards across the Health Board.

3.6 The Health Board should provide us with assurance that the current patient mix on ward 11 has been appropriately thought through and planned.

Staff attitude, behaviour and ability to carry out dignified care

3.7 The ‘Caring Champion of the Month’ initiative should be practice shared throughout the Health Board.

Management of patients with dementia

3.8 The Health Board must ensure that its ‘Violence and Aggression’ policy is available and communicated to all staff at ward level and personal safety / de-escalation training is provided to staff.

3.9 The Health Board should develop, implement and train staff in the application of a policy on how to manage patients with dementia who exhibit exploratory walking behaviour, taking account of human rights issues.

Care planning and provision

3.10 The Health Board should ensure that all in-patients have care plans which are adapted to specific patients needs including nutritional and skin bundle care plans for those who require them and that these care plans are regularly reviewed and updated.

3.11 The Health Board should consider whether additional training / input is required for staff around patients with more complex care needs.

3.12 The Health Board must review the management and monitoring of patients whose condition is deteriorating and ensure that all staff are appropriately trained to recognise the signs of deterioration and understand and follow appropriate escalation procedures.

Communication

3.13 The Health Board must ensure that where appropriate, relatives are fully informed and involved in discussions about a patient's condition and where necessary discussions take place about the decision not to resuscitate.

Fluid and nutrition

3.14 The Health Board must ensure that food and fluid charts are being regularly updated and compliance monitored across the Health Board.

3.15 The Health Board should ensure that full guidance is provided around MUST assessments and following a MUST score, a plan is put in place which is regularly reviewed and updated.

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

Pressure sores

3.17 The Health Board should ensure that patients are provided with pressure mattresses that meet their needs.

Personal care and hygiene

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

3.19 The Health Board should ensure that all patients requiring assistance with mouth care are provided with this regularly to ensure that oral hygiene is maintained.

Buzzers

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

Medicine and pain management

3.21 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 and this plan is regularly reviewed and evaluated.

3.22 The Health Board should ensure that where a patient is prescribed mediation for pain, this medication is administered as immediately as possible.

3.23 The Health Board should conduct its own regular audits of pain assessments and medication administration to ensure it is timely and appropriate.

3.24 The Health Board should ensure that consideration is given to the holistic needs of palliative care patients, involving the palliative care team if a patient needs frequent PRN medication for symptom control and ensuring that staff are confident to use a syringe driver and the All Wales Care Pathway for the Last Days of Life.

3.25 The Health Board should ensure that medication is not left unattended on patient bedside cabinets.

Discharge planning

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

Activities

3.27 The Health Board should consider ways to provide all older in-patients with activities and simulation throughout their hospital stay, taking special consideration for those with dementia.

4. Conclusion

4.1 Overall we observed staff on both wards providing care in a sensitive manner and patients stated that staff spoke to them in a polite and respectful way.

4.2 Ward 1 was involved in Transforming Care and had introduced the 'Caring Champion of the Month Initiative' which we recommended should be shared more widely around the Health Board.

4.3 In general, we found that care for older patients was being provided well, however very limited care planning was evident on the wards we visited. Assessments were being carried out but there was little evidence to show how these assessments shaped a patient's care. This lack of care planning can have a particularly detrimental impact on patients with more complex care needs and we found a few examples of this during our visit including two patients whose condition had deteriorated and there was a lack of appropriate monitoring in response to the deterioration in condition; and a patient on the All Wales Care Pathway for the Last Days of Life whose notes showed that it had taken 24 hours for a prescribed syringe driver to be put in place.

4.4 During our visit some staff raised concerns to us about how to manage patients presenting with challenging behaviour. There was a lack of clarity or knowledge among staff we spoke to about how to manage this or the appropriate safeguarding and escalation procedures they should follow. We have made a recommendation for the Health Board to ensure that its 'Violence and Aggression' Policy is available and communicated to all staff at ward level and personal safety/ de-escalation training is provided.

5. Next steps

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

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

5.3 Healthcare Inspectorate Wales would like to thank Betsi Cadwaladr University Health Board, especially the staff on Wards 1 and 11 who were extremely 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 carryout dignified care.
- Care planning and provision.
- Pressure sores.
- Fluid and nutrition.

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

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

The Dignity and Essential Care Inspections

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

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

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

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

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

Appendix B

The Roles and Responsibilities of Healthcare Inspectorate Wales

Healthcare Inspectorate Wales 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 or 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. We also protect the interests of people whose rights are restricted under the Mental Health Act. 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

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 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; and e) access opportunities to develop collaborative practice and team working.
Management of patients with 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 security (Article 5). Right not to be discriminated against (Article 14). Right to freedom of expression (Article 10).	**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 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; and 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; and 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; and 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** 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.

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 rights10. 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; and 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; and 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; and 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.