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Eich cyf / Your ref
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17 June 2010

Dear Mary

UNANNOUNCED DIGNITY AND RESPECT VISIT: WREXHAM MAELOR HOSPITAL

I write to advise you of the outcome and actions arising from the unannounced 'Dignity and Respect' visit made to Wrexham Maelor hospital on 22 and 23 February 2009 and to thank your staff for their positive and helpful contributions.

Background to Visit

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

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

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

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

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

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

- Our review of the implementation of the Older Peoples National Service Framework (NSF) in Wales.
- Validation of Healthcare Standards self assessments.

Most importantly the visits will be valuable in providing assurance to patients and the public about the quality of healthcare service provision and all management letters and action plans produced as a result of the visits will be published on our website.

The visit to Wrexham Maelor Hospital spanned a 24 hour period over Monday 22 and Tuesday 23 February. This gave our reviewers the opportunity to consider the impact of ward routine and shift changes on patient dignity and to develop an understanding of the culture of the wards visited.

Our visit focused on Glenfro and Alyn wards. Glenfro catered for patients with an organic brain disorder and Alyn Ward for patients with a functional mental illness.

Our general view was that the ward staff had a very caring disposition towards their patients and although the accommodation was temporary and extremely cramped, they did not let this inhibit them from trying to provide a good standard of care.

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The wards we visited were due to move across to the newly developed Older People's Mental Health Unit (Gwanwyn and Hyfred Wards) on 1 March 2010. Therefore our comments should be considered and addressed within the context of the new facility.

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

The staff were very caring and well aware of the need to maintain the dignity of patients. The "key nurse" initiative where each registered nurse is individually assigned to a newly admitted patient and remains their named nurse throughout their stay is practice worthy of note.

The therapeutic culture evident in both wards was also noteworthy. At the time of our visit activities were being provided to patients by two 'activity nurses' with involvement from the ward staff. Activities were based on the patients' day, both in terms of social activities and activities of everyday living. We noticed a number of

attempts by staff to engage individual patients in activities and patients were encouraged to be independent with gentle support. The overall impression was an environment dedicated to stimulation and promoting independence.

We found evidence that patient advocacy services were in use and the development of the "Lotus Group" (drawn from service users and carers, both past and present) had a positive impact on the culture of service provision. This group had been actively engaged in the development of information for service users and carers.

Areas for improvement

The temporary environment was cramped and there was little private space for patients. Medical treatment or examination could be problematic from a dignity and respect viewpoint given the lack of any treatment room, the lack of single rooms and the necessity to examine patients in a dormitory bay with no effective barriers apart from curtains.

Both wards provided care to male and female patients and the layout did not easily lend itself to any form of segregation.

The staff we spoke to demonstrated little formal knowledge of "Fundamentals of Care" (FOC) and no evidence of FOC audits. These are vital to ensure that dignity and respect messages are fully embedded and while it appeared that staff understood the basics, there was no formal framework to enable them to reflect on their own practice.

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

Protected meal times were in operation and appeared to be enforced. All external distractions were removed (such as no television) and no external staff or visitors were allowed. The mealtimes we observed were very peaceful and staff were available to help with feeding if necessary. Although the main meal was pre-chosen we observed patients being offered some choice of food in a relatively unpressurised environment.

The staff on duty were very attentive but also seemed to be able to temper this with encouraging independence.

From our sampling of medical records it seemed that nutritional assessments were carried out on admission and regular reviews of nutritional intake and weight were completed and documented.

Areas for improvement

Concern was expressed by staff on both wards about the limited variety of food available. In particular, the evening meal was seen to be a problem with "jacket potato and beans" appearing on the menu fairly constantly.

We were told that this issue had been raised with the catering department on numerous occasions but no remedial action had occurred.

'Food guides' showing typical food consumption are important since they give a method of determining the amount of food consumed by a patient. It was disappointing to see that these were not evident at the time of our visit, although we were told that these would be available in the new unit.

How suitable is the environment of care?

The two wards are separated into those patients with organic illness (Glenfro ward) and functional illness (Alyn ward). This is recommended as good practice by the Royal College of Psychiatrists.

It was good to see that toiletries were locked away given the possibility of confused patients mistaking such things as fruit flavoured shampoos for normal fruit drinks.

Staff included two nurses with specific responsibility for "activities". It was particularly good to see that activities were focussed on individual patient interests rather than a prescriptive and rigid programme of activities.

An 'Induction Loop' system was available for patients who were hard of hearing and although there was currently little demand, translation services were available.

The 'Lotus Group' had substantial involvement in the way the ward environment was utilised and oriented towards the patients. This approach of carers and ex-patients is a valuable part of adjusting the environment to best suit the patients.

Areas for improvement

For patient safety reasons, a decision had been made to lock some patient personal toiletries in the sluice rather than in their room. We were told that this arrangement was likely to continue in the new unit. This arrangement is not appropriate as clean items should not be stored in the sluice as this is a dirty area and there is the potential for cross contamination to occur.

At present, there are no alarm facilities for patients and there seemed to be confusion over what will be provided in the new unit. The lack of a specific known and agreed plan in this area is not acceptable and needs to be resolved.

Facilities for patients who are visually impaired seem vague. The general consensus seemed to be that the Occupational Therapists would probably have some aids to address this, although this seemed unclear. This is not acceptable and provision for visually impaired patients needs review and action.

A particular issue in the new unit is that there are a number of places where patients can easily be out of view of nursing staff. This is partially because of the much more spacious nature of the wards and the greater number of lounges and quiet rooms

and design of the building. There are concerns that this may have implications for staffing ratios if adequate observation is to be provided.

In the current temporary facility, the toilet and bathroom arrangements are acknowledged to be unsatisfactory as is the provision of lounges where one open space currently serves as a combination of lounge, dining room, quiet room and activities room.

The temporary dormitories where patients were currently sleeping did not lend themselves to adequate privacy.

A lack of storage space means that the shower room on Glenfro ward was being used as a storage area which is unsatisfactory.

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

We found evidence that Multi disciplinary team meetings were held and documented in the patient case notes. Relatives and carers were involved in these meetings as were Occupational Therapists and "Activities Nurses". However there seemed to be a lack of involvement from social care staff and given that these were acute assessment wards this seems an unfortunate lapse.

A Liaison team provides the link between the acute wards, particularly the general medical wards and the older people's mental health unit. This team, which is multi-disciplinary, is led by a Psychiatrist. The team assesses patients who are referred from the acute wards to the older people's mental health services, to ensure that referrals are appropriate and also to ensure that patients receive the most appropriate care.

The Lotus Group play an important part in the overall care regime of patients, for example they provide introductory information for patients and carers describing the functions of the two wards together with practical advice for relatives and carers on how to access all the facilities and resources available.

Areas for improvement

Whilse we believe the approach of having a liaison team providing the link between acute wards and the older people's mental health unit to be a positive one, we identified the following issue. Physicians and other specialists would see a patient on the request of one of the psychiatric medical staff, but staff reported they were reluctant to come and see a patient when requested by the nurse in charge. This was a particular concern during out of hours when psychiatric medical staff may not be available on site. Access to physical medical services is extremely important for this client group who are likely to suffer from co-existing pathologies. The arrangements for this need to be reviewed to ensure all the needs of patients in receipt of mental health services are fully met.

The approach to record keeping is not systematic. Information regarding patients is difficult to find given that it can be scattered among several different files held in several different places, all of which are paper based. Within the main medical record there is a 'Holistic Assessment and Statement of Need', specific separate risk assessment documentation and MAELOR 'MUST' documentation.

The daily notes file, held within the ward office holds the up to date reviews related to the assessments held in the main medical record.

On transfer to the new unit, the only planned computerised facility will be a system to store blank copies of the various forms so that they can then be printed. This is possibly a lost opportunity to introduce an information system designed to reduce paper storage requirements.

Within the patient records we could find little evidence of assessment of individual patient's mental capacity or consent to treatment. These issues need addressing as a high priority.

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

Most of the staff we spoke to had a basic understanding of the issues associated with vulnerable adults, but training in this area was very patchy. Whilst the ward manager had received training recently in respect of vulnerable adults and consent issues, other staff had not received training. One member of staff who was in charge of one of the wards had only received this training as part of her degree programme. The reviewers were unable to identify any formal educational framework for staff.

The POVA policy was on the hospital intranet along with a flowchart showing the logical stages in defining and dealing with a POVA incident,. Although some staff were unaware of this information, they had difficulty describing how "consent" manifests itself and what is meant by "capacity".

There was some awareness of the Knowledge and Skills Framework (KSF) but it was not fully understood by staff. There is a two monthly supervision discussion but this does not appear to form part of any appraisal or personal development process and there is little evidence for defining training needs.

Areas for improvement

There is a general awareness of "vulnerability" among older adults but there has been little formal training among the nursing staff.

Child protection was not seen as relevant, although on expanding the discussions, staff did begin to realise that this could be relevant in terms of discharge planning or child visiting. Again, training in this area is lacking.

There is no formal protocol for child visiting to the existing wards and there appears to be no protocol for child visiting at the new unit. We would expect hospitals where patients may be detained to have appropriate policies and procedures in place for children visiting, in line with the Mental Health Act Code of Practice[1].

Criminal Records Bureau (CRB) checks need to be tightened to conform with the Welsh Assembly Government guidelines which advise a regular check every 3 years.

Our understanding is that all training except mandatory training has been prohibited. This is of ser ous concern given the lack of available training in a number of fundamental areas.

Staff sickness rates seemed high, the evidence behind this has not been explored, leaving the reasons subject to speculation. There may well be some implications for staffing levels in the new unit where patient monitoring may need to be more staff intensive than is currently anticipated.

I should be grateful if you would provide an action plan addressing the areas for improvement raised in this letter by 30 July 2010.

In the interim should you have any queries in relation to the content of this letter please do not hesitate to contact me or Tracey Jenkins on 02920 928913 or email tracey.jenkins@wales.gsi.gov.uk.

I am copying this letter to Richard Bowen and Wendy Chatham at the Department for Health and Social Services, Welsh Assembly Government.

Yours sincerely

Mandy

MANDY COLLINS
Deputy Chief Executive

[1] Mental Health Act 1983, Code of Practice for Wales, chapter 20: Visiting patients in Hospital, Children & Young People.