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23 December 2009

Dear Andrew

UNANNOUNCED DIGNITY AND RESPECT VISIT: YSTRADGYNLAIS COMMUNITY HOSPITAL

I write to advise you of the outcome and actions arising from the unannounced 'Dignity and Respect' visit made to Ystradgynlais Community Hospital on 24 and 25 November 2009 and to thank your staff for their positive and helpful contributions.

Background to Visit

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

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

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

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

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

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

Our visit spanned a 24 hour period between Tuesday 24 and Wednesday 25 November. 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 Tawe ward and the day hospital.

In general the staff provided a caring, gentle and respectful environment for their patients. Particular positive characteristics which stood out included the cleanliness of the physical environment and the flexibility that the staff demonstrated while caring for patients.

We were aware of an extremely strong odour of urine on entering the ward. This was particularly noticeable in the morning. This issue needs to be investigated especially if it is a regular occurrence as it may be an indication that needs of patients are not being fully considered or met.

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

The staff/patient ratio facilitated an individual approach to caring for patients. Staff appeared to be very engaged with patients and this was also reflected in the way that patients were dressed and generally looked after.

Smoking is an issue for patients who were brought up in a very different era and this has been recognised by the provision of a smoking room.

Areas for improvement

The environment imposes some restrictions in the area of privacy. There is a four bedded room and because some patients wander staff are required to exercise great vigilance in order to maintain individual patient's privacy.

The ward catered for both patients with organic brain disorder and also for those with functional mental illness. This is undesirable as mixed functional and organic wards do not ensure an appropriate therapeutic environment for each group.

Of some concern is the fact that many patients are diagnosed with dementia with apparent disregard to the impact of co-morbidities and the effect that this may have on their cognitive state. This may mean that behaviour could be attributed to the dementia rather than any underlying physical health problem. The reliance on cognitive assessment might undermine the pursuit of alternative explanations for behaviour.

There is one bathroom, one shower and two toilets, none of which are designated as single sex. Some solution needs to be found to resolve this issue.

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

Staff supervision of patients at mealtimes is good and relevant assistance for patients seems to be readily available.

Where patients have very specific dietary needs (such as diabetics) this appears to be understood and accommodated.

Areas for improvement

There is an organisational difficulty which arises from incompatible requirements between kitchen staff and ward staff acting on behalf of patients and detracts from the otherwise good working relationship. Kitchen staff deliver the pre-heated meals on trolleys and this is then dispensed to the patients. Unfortunately patients may not necessarily finish their meals before the kitchen staff need to retrieve their trolleys.

Given the increasing dependency of this client group, consideration needs to be given to modifying working practices to better meet patient needs.

Nutritional assessments do not necessarily always appear to be carried out on admission. The reasons may be many and varied, but the fact that a patient is "eating well" is no indication that a nutritional assessment is unnecessary.

We could not find any charts indicating a way of classifying the amount of food not consumed by a patient. This is an important omission since it provides a systematic and consistent way of recording food consumption.

How suitable is the environment of care?

Generally, the physical environment is one which is warm, safe and comforting to patients. Certainly there were no signs of patients actively expressing dissatisfaction. The relatively spacious nature of the layout means that patients who are prone to 'wandering' can actually do this in relative safety and can be observed without too much difficulty. The open space available means that the small amount of clutter (mainly large unwieldy equipment) does not lessen the feeling of spaciousness too much. However, the environment is also rather institutionalised with relatively little personalisation. The

dining room embodies this sort of feeling with large tables rather than a more individual layout. The furniture is also somewhat drab and 'tired' adding to the institutional feeling.

The day hospital appears to be totally integrated into the life of the ward with free interchange of staff.

The fact that a member of the staff travels with patients when they both visit and depart from the Day Hospital is an example of noticeable practice. We believe this to be the case because staff gain a much better insight into patients' social circumstances and there is an opportunity for social interaction en route.

Areas for improvement

Personal toiletries are not kept securely and this represents a patient safety issue which needs to be addressed. Under the Control of Substances Hazardous to Health (COSHH) Regulations 2002[1], chemicals and dangerous substances must be stored and handled in a way that minimises the risks posed by those substances and which limits people's exposure to them. Whilst we recognise that items such as shampoos and conditioners would not necessarily be classed as a chemical or dangerous substance, we do feel that there is a risk of confused older people potentially ingesting such substances especially if they have a fruit like scent.

The television seemed to be in fairly constant use and we felt that it provided the main 'activity' for patients. The lack of focussed therapeutic diversionary activities is poor and some concerted effort needs to be made here.

Observation of patients in their rooms at night is a slightly convoluted process involving adjustment of the roller blinds on the inside of the doors. This needs to be carried out in a few stages to ensure privacy for patients – typically when they are getting ready for bed. While the staff are to be commended for managing within the constraints of the environment with which they are presented, it does seem that better ways could be explored.

The Day Hospital offers a number of day care functions and possibly justifies the 'hospital' tag by holding an assessment clinic each Friday. There is little doubt that the presence of the facilities is of great therapeutic and practical benefit to the attendees. Additionally, ward staff gain an early insight of people who may subsequently become in-patients. However, given the extent of social care support that this facility provides, it was surprising not to see a greater presence of Social Services staff either physically or referred to in some form of documentation.

The ward staff referred to the 'League of Friends' vehicle that had clearly been held in high regard and provided a much appreciated transport service. The reasons for the loss of this vehicle's services were subsequently comprehensively and rationally explained to us by the hospital matron. This explanation needs to be given to the staff so that they do not continue to think that it fell into some sort of organisational gap.

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

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

The overall impression was that patients were not 'involved' in their care and treatment, rather they appeared to be 'treated', albeit in a caring and professional manner. Having said that, one patient was known to like going on shopping trips and this had been arranged via ward management and represents a good example of a patient contributing to the way care is delivered.

Staff believe that any comments from patients would be made known to all staff very quickly, either by informal discussion within this close knit working group or at handover. Our observations of the way staff and patients interact would support this assertion.

Areas for improvement

Examination of patient records showed inconsistencies with regard to the actual involvement of patients or carers in transfer of care planning. In general, it was difficult to find specific endorsement from patients or carers in the patient record (as opposed to being informed on actions).

Transfer of care/discharge planning did not seem to be undertaken at admission reflecting the assumption that patients would be resident for some time.

'Fundamentals of Care' has not yet become part of the staff culture and it we were pleased to see that the new ward manager is making strides in introducing the audit regime to the staff. Every encouragement needs to be given to create added impetus to this initiative.

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

We were pleased to see that the staff at all levels were willing to share responsibilities and this is another indicator that putting the patient first is part of their culture.

There is an understanding of the principles underlying POVA and POCA.

There appears to be a relaxed and cooperative working environment which reflects in the general behaviour towards patients which exhibits the same calm and supportive demeanour.

Areas for improvement

While staff have a general awareness of POVA we would question how high this sits on their priority list. Staff ability to recall training activities and timescales is imprecise and knowledge of appropriate training levels is not well understood or based upon any systematic staff assessment.

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

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

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

Yours sincerely

PETER HIGSON
Chief Executive