Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Cwm Taf Health Board

Unannounced Dignity and Essential Care Inspection

Date of inspection: 29 and 30 October 2012

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Copies of all reports, when published, will be available on our website or by contacting us:

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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1. Introduction

1.1 On 29 and 30 October 2012, Healthcare Inspectorate Wales (HIW) undertook a Dignity and Essential Care inspection at Prince Charles Hospital in Merthyr Tydfil, part of Cwm Taf Health Board.

Dignity and Essential Care

1.2 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.

1.3 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.

1.4 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] 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

Methodology of the Inspection

1.5 The 'Dignity and Essential Care Inspections' review the way a patient's dignity is maintained on a hospital ward/unit 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.

1.6 The inspections capture a *'snapshot'* of the care patients receive on hospital wards/units, which may point to wider issues about the quality and safety of essential care and dignity. More information on how the inspections are carried out is available at Appendix C of this report.

Prince Charles Hospital

1.7 Prince Charles hospital is a district hospital and is part of Cwm Taf Health Board. The hospital has around 430 beds and provides services including intensive care, coronary care and paediatric medicine. Also, on 1 August 2012 a new Emergency Care Centre was opened at the hospital. The centre provides modern emergency facilities to see and treat patients, as well as facilities for trauma, medical and surgical assessment services.

1.8 As part of this inspection we visited the Emergency Care Centre which consisted of the Accident and Emergency Unit (A&E), Short Stay Unit (SSU) and Clinical Decisions Unit (CDU). On the day of our visit the SSU and CDU were being merged into one unit, an Acute Assessment Area.

2. Executive Summary

2.1 Our Dignity and Essential Care Inspection visit to Prince Charles Hospital highlighted a number of areas for improvement that need to be implemented by the Health Board.

2.2 One of the key issues highlighted from the inspection was the length of time some patients were being kept on trolleys. An elderly patient we met in the Acute Assessment Area had a suspected fractured neck of femur and was kept on a trolley for 22 hours. Additionally, there was no system in place to inform waiting patients how long they may have to wait to be seen.

2.3 Concerns were also raised around staffing levels and skills mix on the units given the dependency of the patients. Our concerns were reinforced following discussions with staff, who informed us that they were at times too rushed to spend sufficient time with patients providing them with the care they need.

2.4 Other issues identified on the visit included:

- A lack of awareness demonstrated by some staff in relation to the need for discretion in communication. There were a few occasions when staff were overheard giving patients sensitive information about their condition in public areas.
- Numerous issues in relation to the layout of the units, which gave rise to difficulties in observing patients. These concerns were again echoed by staff.
- Limited communication aids available for patients with sensory impairments.

2.5 Notwithstanding the recommendations made, during our time on the units visited, we witnessed numerous occasions where the interactions between staff and patients was good, generally staff were kind and compassionate.

2.6 Healthcare Inspectorate Wales would like to thank Cwm Taf Health Board and the staff of the Emergency Care Centre who were extremely helpful throughout the inspection.

3. Findings

3.1 We have structured our findings from the inspection around the key areas of Dignity and Essential Care for each unit visited. The recommendations arising from these findings are set out in page 17 of this report.

Accident and Emergency Unit

Unit Environment

3.2 Overall the Accident and Emergency unit (A&E) was calm and peaceful during our visit and the environment was uncluttered and generally clean. However, we identified some walls which were dirty and required cleaning.

3.3 The A&E unit was separated into minor and major injury areas. The minor injury area had eight trolley spaces and the major injury area had seven. Each area had a waiting room and there was a further minor injury sub waiting room in the main corridor to the hospital.

3.4 There was a separate paediatric assessment area available which had a waiting room with toys, books and a television to stimulate the children while they waited to be seen. However, there was no stimulation available for children who were waiting with an adult in the general waiting rooms. We spoke to a patient, waiting in the minor injury waiting room, who was having difficulty keeping her children entertained.

3.5 A number of patients reported that the chairs in the waiting rooms were extremely uncomfortable. One female patient who had been waiting all night told us that her husband had spent the night in his car because he was so uncomfortable sitting on the chairs in the waiting room.

3.6 Further concerns were raised around the sub waiting area for the minor injury unit, as there was no way staff could observe the waiting patients. We spoke to a

patient in a wheelchair who had been waiting for 20 hours and had been vomiting throughout this period. During this time, she had not been checked upon by staff on the unit. This highlighted a number of risks not least patients in the sub waiting area deteriorating without staff being aware.

3.7 Following discussions with staff, concerns were raised around the length of time patients have to wait on trolleys, as it was reported that on occasions patients have waited up to two days for a bed to become available. Staff also reported that the lay out of the Emergency Care Centre made it difficult to locate patients and they believed that *'safer areas for patients were needed.'*

3.8 There were curtains around each patient bed space in the major and minor injury areas. However, we identified that the curtains were not always being used during Doctor consultations to provide privacy to the patient receiving diagnosis/ feedback. On occasions when curtains were used, there were no signs to notify others that care and treatment was taking place. Also, we identified that the mirrors in the minor injury area were poorly placed as patients could be observed when being treated by staff.

3.9 There were designated toilets in the waiting rooms, however there was only one toilet, which was a disabled toilet in the minor injury area and there were no toilets available in the major injury area. This meant that patients in the major injury area had to make their way back out to the waiting rooms to use the toilets there.

Staff Attitude, Behaviour and Ability to Carry out Dignified Care

3.10 The staff on the unit were kind and compassionate. We witnessed numerous examples of good interactions between staff and patients. Furthermore, the feedback we received from patients was positive in relation to staff attitude and behaviour.

3.11 However, staff told us that is was difficult to provide respectful and compassionate service for patients and relatives when the unit is under pressure. They resolved that staffing levels and skills mix is inadequate on the unit given the

dependency of patients. This is a particular issue during night times and weekends on the unit, where Doctors can be too slow in assessing patients.

3.12 We were concerned to observe two occasions where staff provided feedback and diagnosis to patients in public areas despite the availability of side rooms which would have provided privacy, these instances were when:

- A male patient was given a potentially upsetting diagnosis at the nurses station within the minor unit area.
- A female patient who was given her diagnosis and feedback by a doctor in front of other patients in the waiting room.

3.13 During observations, we did not witness any staff using hand gel between patients. We also noted that not all staff on duty on the unit wore an identification badge as a means of identifying themselves to patients and relatives.

3.14 Our discussions with staff highlighted that some staff were unaware of Deprivation of Liberty Safeguards[3] and the Protection of Vulnerable Adults process.

Management of Patients with Confusion/ Dementia & Patients with Mental Health/Psychiatric Condition

3.15 The staff we spoke to informed us that they had not received dementia training and that they felt this would be helpful.

3.16 There were no large pictorial signs on doors to patient facilities to assist patients, especially those with confusion or dementia in locating them.

3.17 It was reported by staff that access to acute psychiatric support was good; however, during our time on the unit a distressed psychiatric patient arrived at 11am and was still waiting to be seen by the Emergency Mental Health Team at 4pm.

[3] The Deprivation of Liberty Safeguards (the Safeguards) are there to protect people whose mental capacity is compromised, who either live in a care home or are patients on a hospital ward. These Safeguards were developed to ensure that the human rights of such individuals are maintained.

During this time it did not appear that the patient was receiving the right level of reassurance from the staff on the unit.

3.18 Staff also reported their concerns that the unit does not have an appropriate area for the management of patients at risk of self harm.

Care Planning

3.19 Good patient assessment documentation was available; however, we identified that assessments were not consistently completed. The care planning documentation in use was comprehensive.

Fluid and Nutrition

3.20 Patients who had been on the unit for extensive periods were provided with soup and sandwiches. However, we noted that water jugs were not always available to patients and staff were not observed routinely encouraging patients to drink.

Pressure Sores

3.21 Risk assessments were evident in patient documentation and those assessments we reviewed were completed appropriately. We witnessed patients being routinely turned. However, discussions with staff highlighted that some were unaware of when to report a protection of vulnerable adult (POVA) referral related to pressure sores.

Personal Care and Hygiene

3.22 Patients on the unit appeared well cared for and Health Care Assistants were on hand to assist with any personal care needs.

Toilet Needs

3.23 As previously mentioned toilets were available in the waiting areas, however not all had emergency buzzers. Also, there were limited toilets available in the minor and major areas with one toilet in the minor area and no toilets in the major area.

3.24 We identified that there was a dirty commode in the unit sluice area. However, this commode had a visible sign attached to inform staff that it had been cleaned and was ready for use.

Buzzers

3.25 During our time on the unit we did not witness any patients using their buzzers; however buzzers were available in all patients' spaces. As noted above, it was identified that there was no emergency buzzer available in the minor injury toilet or the toilets adjacent to the waiting rooms.

Communication

3.26 The unit had good access to translation services and there was a notice in the minor injury waiting area informing patients that there was a loop system available for patients with hearing impairments. However, a number of staff we spoke to were unaware of the availability of a loop system. Also, there was no evidence of any communication aids for patients with visual impairments.

3.27 There was no system in place to inform patients of the length of time they may be waiting to be seen. The majority of patients we spoke to in the waiting rooms raised this as an issue.

3.28 Concerns were raised around the system used to direct patients from the minor injury unit waiting area to triage. A tannoy announced to patients that they could make their way to the triage area. The messages delivered were often difficult to understand and would cause particular difficulties for patients with hearing impairments. Also, the tannoy announcement was advised patients to "follow the

pink arrows to the triage area". These signs were not obvious and could be easily missed, especially by patients with visual impairments.

Medicines and Pain Management

3.29 We identified that not all patients on the unit had an up to date pain assessment. Also, a number of patients we spoke to reported that they felt that their pain was not well controlled by staff on the unit.

Discharge Planning

3.30 During our time on the unit, there were 21 patients waiting for a bed. We identified that there were two patients who had been waiting for over 12 hours for a bed to become available. Also, the majority of patients we spoke to were not aware of the possible next steps in their journey.

Acute Assessment Area

3.31 On the morning of our visit, we were informed that the Short Stay Unit (SSU) and Clinical Decisions Unit (CDU) were going to be merged into one unit – an Acute Assessment Area. Senior Managers from the Health Board informed us when we arrived on the unit that the changes were being made as they had recognised over the previous months that staff had difficulty working within the layout of the two units.

Unit Environment

3.32 The unit was welcoming, visible clean and relatively uncluttered.

3.33 Concerns were raised around the layout of the unit as it was not conducive to good patient observation. For example, the nurse's station faces a fire exit and there are a number of patient rooms located directly behind, which staff can not observe whilst sitting at the station.

3.34 During our visit we identified that two adjacent bays consisted of mixed sex patients. There was no consideration to the relocation of patients to maintain single sex bays.

3.35 There were designated toilets available on the unit marked male or female and en-suite toilets in four of the side rooms, some of which were used to quarantine patients who were considered to have an infection control risks.

3.36 A number of patients we spoke to on the unit were annoyed at the length of time they had been kept on a trolley as the trolleys were “very uncomfortable”. One male patient told us that if he had to spend another night on the unit he would prefer to sleep on the floor instead of on the trolley. We were also concerned to identify that an elderly female patient who had a suspected fracture neck of femur had been kept on a trolley for 22 hours before being moved to a bed.

3.37 Further concerns were raised in respect of the trolleys as patients informed us that they were unable to get off them without assistance due to the high cot sides, hence patients independence was of concern. This was an issue for all patients, even when the trolley was set at the lowest level. For example, we spoke to an able-bodied male patient who was above average height and he demonstrated to us that he was unable to get off the trolley without assistance from a member of staff.

Staff Attitude, Behaviour and Ability to Carry out Dignified Care

3.38 Staff were observed interacting with patients in a sensitive and friendly manner. Also, the patients we spoke to were very complementary of staff attitude and behaviour.

3.39 We overheard Doctors discussing patient care with patients within their rooms in a discrete manner. However, in the patient bay areas conversations relating to patients condition and care could be overheard.

3.40 During our time on the unit there were occasions where staff appeared rushed and staff raised concerns around the staffing levels on the unit on occasions. We

were also informed that staff would like to spend more time at the patient's bedside but the demand on them did not permit this.

3.41 We identified that hand gel was not used and hand washing not undertaken by staff between patient procedures. Also, not all staff on duty on the unit wore identification badges as a means to identify themselves.

3.42 The staff we spoke to all had an awareness of the Protection of Vulnerable Adults (POVA) process however staff were unaware of the Deprivation and Liberty Safeguards.

Management of Patients with Confusion/ Dementia & Patients with Mental Health/Psychiatric Conditions

3.43 There was no initiative in place on the unit to identify patients with confusion or dementia and to assist staff in caring for these patients. Also, staff had not undertaken any training in this area. During our inspection we identified a few concerns around staff attitude and awareness towards patients with dementia. These included:

- Staff who were attending one patient gave no indication that they had identified that she was displaying signs of dementia. They were observed speaking to her in an insensitive and patronising manner.
- Following a review of the medical records of a patient who was clearly displaying the early signs of dementia, we were concerned to note that staff had documented statements such as *'patient has been demanding buzzing/banging table,'* '*patient banging to gain attention'* and *'patient less demanding today.'* These statements lacked compassion and appeared to demonstrate that staff were ill-informed.

3.44 There were no large pictorial signs on doors to assist patients, especially those with dementia to locate them.

3.45 In contrast, following discussions with staff and a review of a selection of patient medical records it was highlighted that there was good support in place for patients with a psychiatric condition.

Care Planning and Provision

3.46 Patient assessment and care planning documentation was available in some patient records; however they were not being consistently completed and evaluated by staff. There was a particular lack of MUST[4] assessments and falls risk assessments. However, some examples of good care planning in place were noted.

Fluid and Nutrition

3.47 All patients on the unit were offered cooked meals and the majority of patients were complementary in relation to the quality of the food. However, we did not observe regular fluid being offered to patients and we also identified that water jugs and cups were not always positioned within reach of patients.

3.48 There was no system in place to indicate which patients required assistance during meal times and we observed patients who clearly needed help and support to eat their meals struggling unassisted.

3.49 Protected meal times were not in operation and we observed a few occasions where patients received treatment during this meal time. One example of this was an elderly patient with very limited vision and with a suspected fractured neck of femur who was taken for an x-ray moments before her lunch was going to be served. The patient asked the porter if she could have her meal before she went for an x-ray and he said she would have to have it when she returned. The patient's hot meal was left on her bedside table until she returned around an hour later, when she informed staff that she no longer felt up to eating her meal.

[4] MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under-nutrition), or obese

3.50 There was no evidence of any food charts being used on the unit, despite a number of patients requiring one.

Pressure Sores

3.51 Patient turns were being documented. However, pressure relieving mattresses were not being fully utilised on the unit for those patients at risk of pressure sores. One patient reported that she had been left in a wheelchair for two hours on arrival to the unit and was *'in agony'* by the time a pressure bed was provided.

3.52 As previously mentioned concerns were raised around the length of time patients were kept on trolleys, in particular patients at risk of pressure sores.

3.53 There was no evidence of safety crosses[5] being utilised on the unit.

Personal Care and Hygiene

3.54 Some patients on the unit had received oral hygiene assessments; however the assessments were not consistently completed by staff.

3.55 We identified a number of examples where the patient's personal care and hygiene needs had not been met. One patient informed us that he had not washed for two days and another patient informed us that she had not been able to clean her teeth since her admission to the unit 24 hours previously.

3.56 We did not observe patients being offered the opportunity to wash their hands before meal times.

[5] Safety cross is a tool used to raise awareness within team regarding how many ulcers are acquired in care area and also to promote good practice.

Toilet Needs

3.57 During our time on the unit we observed patients being supported by staff to use the toilet method of their choice.

3.58 There were two commodes available, however we identified that they were both dirty despite there being a visible sign attached to one of the commodes indicating that it had been cleaned and was ready for use. Also, we were concerned to observe a Healthcare Support Worker (HCSW) who was removing a used commode from a patient bed space and taking it to the sluice area. The HCSW removed the urine soaked wipes from the commode and place them in the bin; she then continued to carry out different tasks in the room without changing her gloves. Further following discussion with this member of staff it became clear that she was unaware of the procedure for notifying other staff that the commode had been cleaned and ready for use.

Buzzers

3.59 During our time on the unit we observed staff answering buzzers promptly. However, a few patients we spoke to informed us that staff are not always quick to answer buzzers when the unit is busy.

3.60 Some patients on the unit including an elderly patient who was blind, did not have their buzzer positioned within their reach.

Communication

3.61 We spoke to a number of patients on the unit who were hard of hearing and none of them were aware of any loop system being available on the unit, despite there being a sign in the main reception area stating that there was one. Also, there was no evidence of any communication aids for patients with visual impairments.

3.62 The majority of patients we spoke to on the unit informed us that staff had involved them in discussions about their care and treatment. However, our

discussions highlighted that patients had not been provided with information regarding their discharge from the unit.

Medicines and Pain Management

3.63 There were no issues raised by the patients we spoke to in relation to pain management. However, we identified that not all patients on the unit had had a pain assessment making it difficult to assess how pain was being measured and monitored by staff.

3.64 We were concerned to note that in some instances patient's tablets were left on their bedside tables by staff, for them to take without supervision.

Discharge Planning

3.65 As previously mentioned, the patients we spoke to informed us that they were unaware of the plans for their discharge from the unit. One of the patients we spoke to informed us he had not been told when he was likely to be discharged, however he was discharged 45 minutes after speaking to us.

Activities

3.66 There were no televisions or radios available on the unit. A number of patients we spoke to told us that they were bored and one patient in particular, who was isolated in a single room due to the risk of infection following chemotherapy, stated that as he did not have a television or radio and as his bed faced the clock all he could do was continuously watch the clock which led to distressing thoughts.

4. Recommendations

4.1 Findings and associated recommendations were provided through verbal feedback throughout the inspection and more formally at the feedback meeting held at the end of the second day of the visit. Any immediate concerns emerging from the inspection were also notified to the Health Board via a management letter, following the inspection, so that immediate action could be taken.

4.2 In view of the findings arising from this review we make the following recommendations.

Reference	Recommendation	Paragraph Reference
Unit Environment		
1.1	The Health Board should ensure that systems are in place to maintain acceptable level of cleanliness on all units.	3.2
1.2	The Health Board should review the provision of stimulation available for children who accompany adults.	3.4
1.3	The Health Board should review the current seating available in waiting rooms.	3.5
1.4	The Health Board should ensure that systems are in place to ensure that all waiting patients are routinely observed.	3.6
1.5	The Health Board should undertake a review of the length of time patients are on trolleys in the context of all aspects of the fundamentals of care.	3.7, 3.36, 3.37
1.6	The Health Board should ensure that staff are aware of the importance of closing curtains during patient consultations on units.	3.8
1.7	The Health Board should ensure that measures are in place to inform others that care and treatment is taking place behind closed curtains.	3.8
1.8	The Health Board should ensure that the mirrors in the minor injury unit are moved to protect patient privacy and dignity.	3.8
1.10	The Health Board should review the availability of toilets in the minor and major injury units.	3.9, 3.23
1.11	The Health Board should provide HIW with assurance that the merging of the Short Stay Unit and Clinical Decisions Unit has resulted in the required improvements in patient care.	3.31
1.11	The Health Board should review the layout of the unit area to ensure that the facilities and staffing levels allow for adequate observation of all patients at all times.	3.33

Reference	Recommendation	Paragraph Reference
1.12	The Health Board should ensure that staff are aware of the importance of maintaining single sex bays where possible.	3.34
Staff Attitude, Behaviour and Ability to Carry out Dignified Care		
2.1	The Health Board should ensure that all staff are aware of the importance of treating patients with dignity and respect.	3.11
2.2	The Health Board should ensure that all staff are aware of the importance of discretion when discussing sensitive information.	3.12, 3.39
2.3	The Health Board should review its current staffing levels to ensure that patient care is not regularly compromised due to short staffing.	3.12, 3.40
2.4	The Health Board should ensure that all staff are aware of the importance of washing their hands before moving from patient to patient.	3.13, 3.41
2.5	The Health Board should provide Protection of Vulnerable Adults awareness training to all staff.	3.14
2.6	The Health Board should provide Deprivation of Liberty Safeguards training to all staff.	3.14, 3.42
2.7	The Health Board should ensure that all staff wear identification badges as a means of identify themselves to patients whilst on duty.	3.13, 3.41
Management of Patients with Confusion or Dementia & Patients with Mental Health/psychiatric condition.		
3.1	The Health Board should review its process for the management of psychiatric patients being cared for in the A&E unit, to ensure that they receive the necessary level of care and support.	3.17
3.2	The Health Board should ensure that there is a psychiatric care room which has been risk assessed to ensure it is free from potential risks of self harm.	3.18
3.3	The Health Board should provide dementia awareness training to staff.	3.15, 3.43
3.4	The Health Board should ensure that large signs are available on patient facilities such as bathrooms and toilets.	3.15, 3.44
3.5	The Health Board should consider the implementing an initiative to identify patients with confusion or dementia.	3.43
Care Planning and Provision		
4.1	The Health Board should ensure that patient assessments are routinely fully completed and regularly updated by staff.	3.19, 3.46
4.2	The Health Board should ensure that care plans are fully completed and evaluated by staff.	3.46
Fluid and Nutrition		
5.1	The Health Board should ensure that there is a system in place to ensure that fluids are routinely made available to all patients within easy reach and staff routinely encourage patients to drink.	3.20, 3.47

Reference	Recommendation	Paragraph Reference
5.2	The Health Board should consider implementing a system to help staff identify which patients on the units require assistance to eat.	3.48
5.3	The Health Board should consider implementing protected meal times on the new Acute Assessment Area.	3.49
5.4	The Health Board should ensure that food charts are appropriately completed for patients who require them	3.50
Pressure Sores		
6.1	The Health Board should ensure that staff are aware of the POVA referral process and criteria for referral in the context of pressure sore grading.	3.21
6.2	The Health Board should ensure that patients at risk of pressure sores are appropriately provided with a pressure relieving mattress.	3.51
6.3	The Health Board should ensure that safety crosses are in place which are fully completed and regularly updated by staff.	3.53
Personal Care and Hygiene		
7.1	The Health Board should ensure that oral hygiene assessments are consistently completed by staff.	3.54
7.2	The Health Board should ensure that all staff are aware of all and adhere to all aspects patient personal care needs.	3.55
7.3	The Health Board should ensure that patients are provided with the opportunity to wash their hands before meal times.	3.56
Toilet needs		
8.1	The Health Board should ensure that a consistent approach to the effective cleaning of commodes is put in place and a visible sign to indicate the commode is cleaned and ready for use is attached to it.	3.24, 3.58
8.2	The Health Board should ensure staff are aware of training as to when it is appropriate to wash their hands, use alcohol gel/foam and when to wear and remove gloves.	3.58
Buzzers		
9.1	The Health Board should undertake a review of the availability of emergency buzzers in all patient areas.	3.25
9.2	The Health Board should ensure that staff aim to answer buzzers/ call bells promptly or provide an explanation and reassurance to patients if they are unable to do this because they are busy.	3.59
9.3	The Health Board should ensure that all patient buzzers are within their reach.	3.60

Reference	Recommendation	Paragraph Reference
Communication		
10.1	The Health Board should ensure that communication aids are available on the units to assist patients with sensory impairments and that staff are aware of them.	3.26, 3.61
10.2	The Health Board should ensure that systems are in place to notify waiting patients of the length of time they maybe waiting to be seen.	3.27
10.3	The Health Board should review the current communication system for directing patients through to triage in the minor injury unit to ensure that it appropriately meets the needs of the communication needs of all patients.	3.28
Medicine and Pain Management		
11.1	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 regularly reviewed and evaluated.	3.29, 3.63
11.2	The Health Board should ensure that there systems in place to ensure that patients who require pain relief are routinely provided with pain killers.	3.29
11.3	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.	3.64
Discharge Planning		
12.1	The Health Board should ensure that all patients and, where appropriate, relatives are kept fully informed and involved in discussions about their discharge from the unit.	3.30, 3.62, 3.65
Activities		
13.1	The Health Board should consider ways to provide patients in the Acute Assessment Area with stimulation throughout their time on the unit.	3.66

5. Next Steps

5.1 The Health Board is required to complete an action plan to address the key issues highlighted in this report 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 units 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 Cwm Taf Health Board, especially staff from the Emergency Care Centre who were extremely helpful throughout the inspection.

Appendix A

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.

Appendix B

Background and Methodology for the Dignity and Essential Care Inspections

Healthcare Inspectorate Wales' (HIW's) programme of Dignity and Essential Care Inspections (DECI) commenced in November 2011.

The inspection team comprises a HIW inspector, two practising and experienced nurses and a *'lay'* reviewer.

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

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.

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.

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. 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). 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	**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

	security (Article 5). Right not to be discriminated against (Article 14). Right to freedom of expression (Article 10).	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. 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. 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. e) Is accessible 24 hours a day.
Pressure sores	Right not to be tortured or treated in an inhuman or degrading way	**8. Care planning and provision** Organisations and services recognise and address the needs of patients, service

	(Article 3).	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 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. **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. 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. 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. 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.

Appendix D

Cwm Taf Health Board A&E Performance Statistics

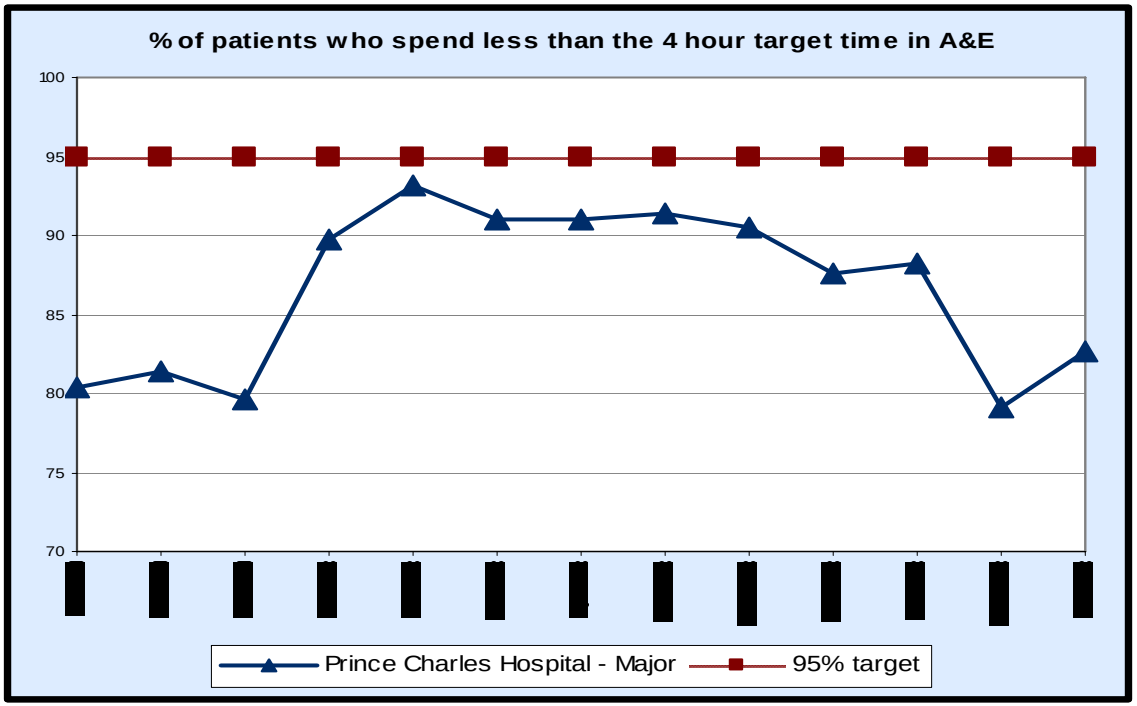
The Information below sets out the hospitals performance over the past year against the four hour and eight hour A&E target for patients. The Welsh Government's target for current target is 95% of new patients to be admitted, transferred or discharged within four hours and for 99% within an eight hour period. The target line in the charts shows how the particular hospital is performing in relation to the target.

This data is published on a monthly basis as management information by the NHS Wales Informatic Service. The data is derived from the monthly Emergency Department Dataset (EDDS) submitted to the informatic service by Health Boards.

The information below sets out the hospitals performance over the past year against the 4 hour A&E target for patients.

The current target is 95% of patients to be seen in under four hours.

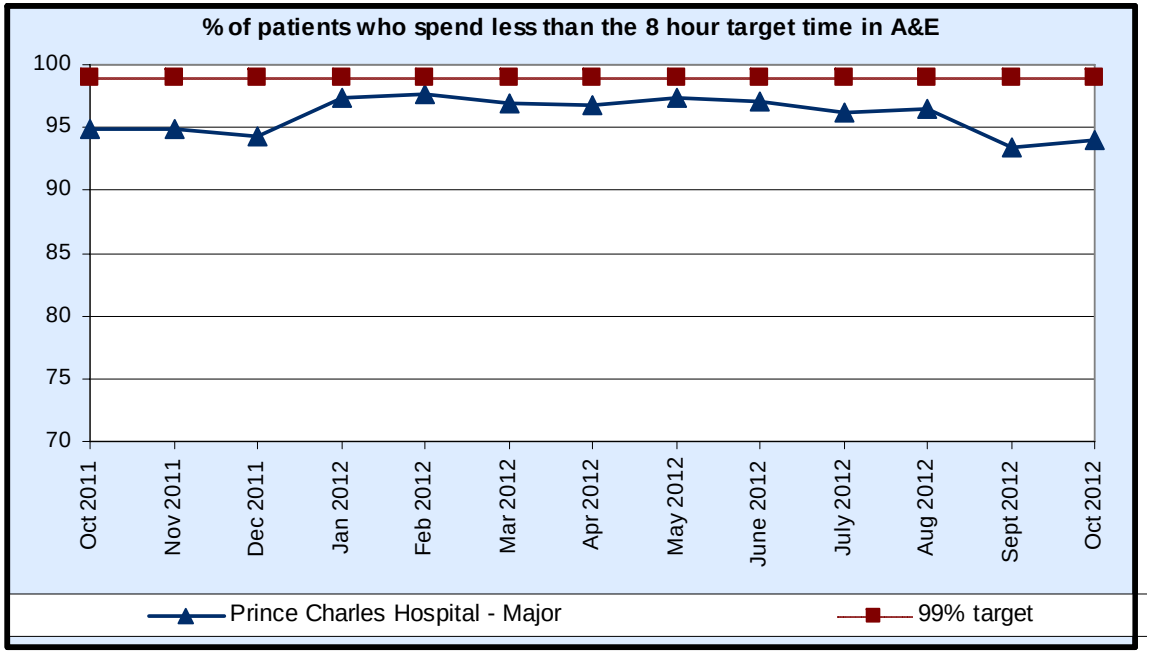
	4 hour target												
	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sept 2012	Oct 2012
Prince Charles Hospital - Major	80.42	81.41	79.64	89.72	93.11	91	91	91	91	88	88	79	83
95% target	95	95	95	95	95	95	95	95	95	95	95	95	95



The information below sets out the hospitals performance over the past year against the 8 hour A&E target for patients.

The current target is 99% of patients to be seen in under eight hours.

	8 hour target												
	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	June 2012	July 2012	Aug 2012	Sept 2012	Oct 2012
Prince Charles Hospital - Major	94.9	94.9	94.3	97.3	97.7	96.9	96.8	97	97	96	96	93	94
99% target	99	99	99	99	99	99	99	99	99	99	99	99	99



Appendix E

Action Plan Template

Recommendation Reference	Recommendation	Health Board Action	Responsible Officer	Target Date