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Eich cyf / Your ref
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23 December 2009

Dear Andrew

UNANNOUNCED DIGNTY AND RESPECT VISIT: CHEPSTOW COMMUNITY HOSPITAL

I write to advise you of the outcome and actions arising from the unannounced 'Dignity and Respect' visit made to Chepstow Community Hospital on 2 December 2009 and to thank your staff for their positive and helpful contributions.

Background to visit

As you may be aware we announced our intentions to undertake such unannounced site 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 ward environment and the care and treatment being provided at the time of our visit.

We also consider other issues 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 these visits 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 for 2009-10. 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 web site.

The visit to Chepstow Community Hospital on 2 December 2009 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. The visit focused on Llanvair and St Pierre wards.

As you will be aware, Llanvair ward is a 12-bedded unit for dementia assessment for the borough of Monmouthshire. The older adult service provides assessment/continuing and respite care to patients over the age of sixty-five who have mental health problems. While St Pierre is a twenty-two bedded ward for patients with complex discharge needs. It was reported that 70% of the current patients on this ward had dementia or mental health needs. Both wards appeared clean and tidy with no visible clutter.

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

All staff had basic understanding of the needs of the patient group in relation to privacy and dignity.

The nursing care we observed was caring and responsive. Patients were addressed by their preferred name, and spoken to in a respectable manner

Good management of patients with challenging behaviour on Llanvair ward was witnessed.

While patients are encouraged to wear their own clothing, which helps detract from a potential 'institutionalised' approach, there was evidence of a wide range of hospital clothing available if and when necessary. Relatives were encouraged to take used/soiled clothing for washing and for those patients who had no frequent visitors there was a laundry service available in Caldicot, which incurred a charge for the patients using it.

There is a hospital Chaplain service that is readily available, which involves twice weekly visits to the wards. Ministers of the various religions are readily available on request.

The use of the Patient Transport Service on Llanvair ward was reported to be prompt after a referral was requested. However, it was reported on St Pierre ward that delays are experienced when patients are being transferred from Gwent hospital onto the ward.

Areas for improvement

Some patients on Llanvair ward were in need of high care and regular observations. However, they were being cared for in separate ward areas making regular observations difficult. It was observed that one patient in particular was in a bay area with the doors locked. The reason given was to ensure the patient's safety from other wandering patients. It was suggested to the manager at the time that high-care patients would be better nursed in the 4 bedded bay area opposite the nursing station so that ongoing observation is easier and would reduce the risks associated with other wandering patients. It is also necessary for a full assessment to be undertaken when any patient is locked in a room to manage issues regarding deprivation of liberty safeguards.

There was no evidence of any activity plans within the patient records or any activities planned to take place with the patients. It was reported that the Occupational Therapist (OT) on Llanvair ward was on maternity leave and that no replacement cover had been available. Whilst on St Pierre ward the OT was only reported to be available for home assessments with no activities provided during the patient's stay in hospital One patient on this ward reported that there was nothing to do all day and it was "*very boring*" sitting by the bed. On both wards Physiotherapy cover was not reported as being good, with the main access to this service being provided from the clinics in the rest of the hospital on a '*good will*' basis.

The curtains around patients' beds on both wards were only three-quarter length thus providing little privacy and dignity to patients when being examined on the bed or sitting on the commode beside their bed.

There were curtain tracks in the bathrooms but no curtains were in place and there was no opaque glass in the doors to the 4-bedded bay areas thus comprising patients' privacy.

There was inappropriate storage in the bay areas that were not fully occupied. This was on Llanvair ward where two of the four beds within a bay area were not in use and the curtains were drawn around them. Behind the drawn curtains were stored hoists, wheel chairs, specialist seating etc. It is important to add that patients occupied the other two beds in that bay resulting in them having to observe curtains constantly drawn around the beds opposite them.

There was a lack of suitable rooms for people to have quiet or confidential conversations on both wards and confidential conversations which take place behind curtains can be overheard by other patients in the bay area.

There was no evidence of signs/notices being used to indicate when care or treatment was in progress behind pulled curtains.

It was acknowledged on St Pierre ward that there was a lack of understanding and knowledge when nursing patients with physical conditions/needs who also had a mental

health diagnosis e.g. dementia. The nurses on this ward were registered general nurses. This was a relevant concern as at the time of the visits it was reported that approximately 70% of the patients on that ward had a mental health condition as well as a physical one.

It is understood that there are plans to consider a future integrated model of care for these elderly patients who have a dual physical/mental health diagnosis. In the meantime consideration should be given to develop and deliver training to these general trained nurses regarding nursing patients with mental health conditions.

Within the patient's personal details record, their religion was not always recorded. This could result in a gap in their spiritual needs not being assessed and addressed within a holistic approach to the provision of care to an individual.

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

On Llanvair ward communal eating is encouraged in an attempt to promote social interaction but patients have the choice of eating beside their beds if this is preferred or more suitable.

On St Pierre ward all patients sat within their bed space area to have their meals.

There is choice and some variety in menu provision. The relatives or nurses usually make these choices according to the patient's likes or nutritional needs as the majority of patients are very confused.

The approach to nutritional assessment and monitoring was consistent on both wards with patients being weighed each month and the results recorded in a separate ward weight book.

Protected meal times are a formal arrangement, with visits from medical and other hospital staff discouraged during these times.

Assistance with feeding was observed and seen to be appropriate and relatives are encouraged to visit and assist at mealtimes if necessary.

The food was presented well on the plates and kept warm until a nurse was available to help the patient who required assistance, as there were several patients who required assistance on both wards.

Appropriate cutlery was available and observed to be used where appropriate and necessary.

Areas for improvement

Provision of snacks and out of hour's food was not readily available. The only provision was biscuits and some extra sandwiches that would be ordered for suppertime. This was the main source of availability of additional food /snacks.

There was no kitchen facility on St Pierre ward so the kitchen on the ward opposite (Llanvair) was used. A food trolley was used in the day room area to dish out the daily meals, which were taken to the patient at their bedside on a tray. The making of drinks was also carried out in Llanvair ward's kitchen and then brought across to St Pierre ward on a trolley. This situation is not ideal as it means ward staff on St Pierre have to leave the ward to make drinks and collect any snacks (if available), when required outside regular meal times.

We were informed that work is currently being undertaken to integrate both wards to provide a *'shared care'* facility. It is hoped that this would lead to improvements in the kitchen provision.

It was observed that the portions of food offered to the patients were according to their appetites with the quality reported to be variable. One patient on St Pierre ward who had been an inpatient for eight weeks stated, "I *am not impressed with the quality*".

The pureed food was tasteless, bland and with little choice or variety.

How suitable is the environment of care?

The areas appeared clean and clutter free.

Access to both wards was by push button and exit was facilitated by staff using a swipe card. This is seen as an appropriate way of monitoring access to these types of wards as long as the system is managed correctly and patients are given appropriate information on how to enter and exit the ward enabling those with the capacity to do so.

The provision of some single rooms and gender specific 4-bedded bays was adequate and efforts were made to ensure genders were at either end of the ward areas.

Bathrooms and toilets are lockable and accessible, all appeared clean and clutter free and the locks could be overridden in an emergency.

The designated storage space although limited appeared clean and tidy, due to the lack of designated space some items are stored inappropriately e.g. the linen room is used to store trolleys and hoists.

Areas for improvement

The first impression on entering both areas was of a very clinical environment. Both areas were designed as medical rehabilitation wards and this is reflected in the layout and design of living and bed spaces.

The current use of these areas requires a balance between clinical and therapeutic environments of care.

The doors to all areas in both wards are a very high risk in regards to health and safety and require a risk assessment and in some cases replacement. The inability to open the doors both ways means that if patient barricades themselves in a room, or falls behind the door, access cannot be gained.

It is acceptable that a patient can lock their door by choice but the override system is totally inadequate, currently a coin has to be used to open the lock.

Llanvair ward did not have gender specific toilets or bathrooms. This needs to be addressed as a matter of urgency with appropriate picture signage put on the doors to help confused patients identify gender specific toilets.

Signage on both wards needs to be reviewed, the current signage is in small print and no pictograms or directional indicators are in use. Clear signage and pictograms would promote independence in daily living activities.

Currently there are no names evident on the doors to bedrooms/sleeping areas. Bedroom doors should have a secure 'slot in frame' for patient names to support patients in locating their own rooms.

There was an inconsistency with the wearing of name badges, which made it difficult to identify staff members and there was no information board which contained up to date staff pictures or names.

There was a general lack of information and information leaflets available on both wards. The opportunity to use the small entrance foyer outside the wards could be taken to provide a central information point for this patient group. The reviewers found no evidence of information on how to voice a concern or make a formal complaint.

Resources to support patients with a sensory impairment are lacking apart from the availability of audio books. There seems to be a dependence on the individual approach by staff. This can lead to patients feeling isolated and staff being either unaware or unconcerned to patients' needs.

St Pierre ward does not have an available day room space for patients to use. The designated dayroom is currently used for staff meetings and has to be used to serve patients meals. This room would need a full refurbishment to become a dayroom again.

Llanvair's dayroom has been converted from a 4-bedded area which has resulted in all the fittings for medical gases etc to be still in place. It is felt that such fittings are inappropriate as the room is used by patients as a sitting area and should be relaxing, therapeutic and welcoming. There is no quiet room/space available on either ward other than by patient's bedside.

Both areas require a full review of dayroom and bedroom furniture. Some of the current furniture is in need of immediate replacement due to damage to fabric, which presents an infection control issue and much of the remaining furniture is old.

Patient toiletries were individualised but stored in unlocked draws by patient beds, 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

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

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.

Washing bowls used for patients were stored on top of wardrobes, to prevent infection control issues these should be cleaned, inverted and contain no items.

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

Multi disciplinary communication is viewed by staff as extremely positive, especially the formal multi disciplinary meetings. There is evidence that family/carers are invited to these meetings.

Team working within both wards and Chepstow social workers was reported to be excellent and effective. Communications with social workers outside the Chepstow area was not as effective as they were not so readily available.

The development of a psychiatric liaison nurse has resulted in an improved service for those patients on medical wards requiring a psychiatric assessment, this was particularly valued by the St Pierre nursing team.

We were provided with the planning notes for the shared care project that is currently being undertaken and would commend this project as a way to develop a fully holistic care environment for the patient group.

Staff handover followed a structured process that enabled good information sharing and identification of specific staff responsibilities.

Areas for improvement

Patient records are currently kept in paper format only. The wards visited were under different management streams so there was no uniformity in record keeping.

It was evident that staff were using core care plans and although these covered key aspects of care they did not really reflect individualised care. There was little to suggest that service users and carers are involved in care planning, for example no signatures were seen to indicate that care plans had been discussed and agreed.

The use of Care Programme Approach (CPA) or Unified Assessment (UA) was very variable and staff recognised that this was a deficit that needs to be rectified.

There was little understanding or knowledge of the Fundamentals of Care (FOC) throughout the grades of staff, which shows that this is not imbedded in practice. This lack of knowledge requires attention from the ward managers. There was evidence of the All Wales FOC audit earlier this year, but the results of this audit are still awaited. This knowledge about the audit appeared only to be at ward manager level, so it was unclear how the audit results were shared with the nursing staff.

Formal systems for assessing and recording capacity and consent were not evident. It was reported that it was the role of the Consultant to make that assessment. We were told that explanations to patients and consent are noted verbally. This approach needs to be improved and staff need to access appropriate training on issues involving consent and the Mental Capacity Act.

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

On Llanvair ward, the manager felt that staffing levels were appropriate and that she was involved in workforce planning. We were unable to interview the ward manager on St Pierre ward, but the band 6 nurse felt that there was a need for one more healthcare support worker per shift.

There is a great emphasis on training being undertaken via the intranet.

Areas for improvement

The use of appraisal and PDP was very poor, although most staff had undertaken mandatory training. The lack of staff appraisal/PDP needs addressing to facilitate the implementation of the Knowledge and Skills Framework.

The difference in the level of knowledge and training between the manager and other staff is noticeable. This should be rectified and the organisation needs to provide a clear route of dissemination of information through to all grades of staff. It was evident from all staff interviews that there are deficits in the understanding and training for consent, capacity, POVA and POCA.

The knowledge of POVA and POCA again seemed focussed above band 6 level, the organisation needs to ensure this knowledge is embedded throughout all levels of the organisation. It was of concern that no one knew who the lead was for either of these areas within the organisation.

Where training is provided via the intranet, an audit process should be in place to ensure that the individual has understood the content.

Not all staff had Criminal Record Beaurea (CRB) checks. It is understood that this is an issue for all NHS organisations but does need addressing.

I should be grateful if you could provide me with 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 Sue Gregory at the Regional Office.

Yours sincerely

Peter

DR PETER HIGSON
Chief Executive