

'Dignified Care?'

The experiences of
older people in hospital
in Wales



Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

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Ruth Marks, Older People's Commissioner for Wales

As the independent Older People's Commissioner for Wales, this Review, with its call for change, reflects my commitment to representing the reality of older people's experiences of healthcare in Wales. I consider that my Review has highlighted that the treatment of some older people in Welsh hospitals is shamefully inadequate. Organisations must do more to learn from those who are doing things well.



Following wide consultation, especially with older people themselves early in 2010, I chose to use my legal powers of Review to explore the treatment of older people in hospital in relation to dignity and respect. I wanted to look at the actual experiences of older people themselves on the wards across the country.

I established an expert Panel of Inquiry to gather evidence and to advise me as I developed my recommendations. I am very grateful to the Chair of the Panel, Dame Deirdre Hine, and to all the Panel members for their dedication to this task over the past year, and for the wealth of knowledge and experience they have brought to it.

I want to thank all those older people, members of the public, hospital staff and the numerous organisations who have played such an important part in this Review by giving written and oral evidence, and by speaking to Panel members during the hospital visits. I have been moved by many of the personal accounts which have been contributed, and I recognise the efforts individuals have made in the often difficult process of setting out personal experiences.

These accounts mean that the voices of older people, their relatives, carers, fellow patients, advocates and staff are strongly present throughout the Review report and really have made a difference to our understanding of what is happening in hospitals in Wales.

I am concerned about the low expectations that many older people have of their care. We need to see people expect more. We found evidence of poor practice and this needs to stop.

Older people have the right to be treated with dignity and respect and failures to manage continence, or to address people's communication and privacy needs for example, are simply unacceptable.

I recognise the challenges facing public services in Wales as a result of the current economic climate. We must not, however, allow this to result in unacceptable standards of care or to compromise the care given to vulnerable people. Resources need to be appropriate for the task and there must be more effective joined up work across the system to achieve better results more efficiently. We have seen examples where despite resource pressures, a positive culture of care is being achieved.

There are examples of effective leadership and good practice and it is vital these are built on and become regular practice. There is evidence that efforts to improve standards of care are making a difference and we should take encouragement and learn from this. They demonstrate what is possible and should play a key part in bringing about wider change.

I hope this Review will provide support for all those wanting to see positive change, and will strengthen the resolve of many people who are striving to deliver quality care in the health service. I have made a number of recommendations and will use my statutory power to follow these up.

I want my Review to lead to change in practice and for that change to be measured through the experience of patients themselves. I recognise the many strategies, reports and initiatives which aim to make dignity and respect central to care and I trust that my Review will add real momentum to a direction of travel which is widely understood by members of the public and professionals to be vital.

Fundamental change is needed. Patients need to know what quality care is, and staff need to be supported by systems and resources to empower them to meet patient's expectations. Poor practice should not be tolerated. The attitudes, behaviour and emotional intelligence of staff on the wards are crucial. We need strong, positive leadership at all levels, and a system which builds in dignity and respect as the cornerstone of high quality care.

Ruth Marks

Older People's Commissioner for Wales

Foreword

Dame Deirdre Hine, Chair of the Panel of Inquiry

I was honoured to have been asked to chair the Panel of Inquiry for this, the Commissioner's first Review. The achievements of healthcare in Wales, as in other parts of the UK, have led to a rapid rise in the number of us who will survive into old age.

In celebrating this success we must, however, recognise that many older people will require hospital care at some point and that they are already, and will increasingly be, the main users of hospital inpatient care.

It is important therefore that the care they receive in hospital is of high quality in all its aspects and that it is given with compassion and with understanding of the need to preserve the, often fragile, self esteem of these older patients.

It is imperative then that the dignity and respect with which older patients are treated is at the forefront of the minds of all who manage and staff our hospitals in Wales. Attitudes and practices that assault the dignity and self esteem of older people at a time when they are most anxious and vulnerable must be stopped.

Over the past year I have been privileged to lead a Panel of experienced, well informed and committed colleagues in this Inquiry into the recent experiences of older patients treated in hospitals in Wales. Together we have been given access to the views of patients and their relatives through written submissions and through visiting and hearing the views of older patients on medical and surgical wards. We are grateful to all the patients, relatives and staff who have so readily assisted us.

Three vivid impressions emerge. One is of the appreciation of the majority of older patients for the care they receive. Another is of the sheer courage with which so many of them face up to and manage illnesses and disabilities that impact on the quality of their lives. And the third is the determined efforts of so many health care staff to do their best for every patient they treat.



Hospitals in Wales are making steady progress in meeting the demands of the dignity and respect agenda, however our findings show that there is still work to be done to make it a consistent reality at ward level across NHS Wales.

It has been a pleasure to work with the Commissioner and her expert and dedicated staff on this Review and I hope that our collation of the evidence, our analysis of the outstanding problems and our suggestions for change will enable her to make recommendations that can be shown to achieve such a reality.

Dame Deirdre Hine

DBE FFPH FRCP



The Hospital Review Panel of Inquiry was made up of six members (from left to right): Meg Edwards, Monty Graham, Dame Deirdre Hine (Chair), Meirion Hughes, Nicky Hayes and Dr Charles Twining.

Introduction

Why the Commissioner conducted the Review

The Commissioner for Older People (Wales) Act 2006 provides the Commissioner with a range of legal powers, and an obligation to listen to the views of older people, aged over 60. This Review has been conducted under Section 3 of the Commissioner for Older People (Wales) Act, which allows the Commissioner to review the effect on older people of how Welsh public bodies and providers deliver their functions.

This report is produced under the Commissioner for Older People (Wales) regulations.¹

Since the Commission was set up in April 2008, the Commissioner has travelled widely across Wales and through her conversations with older people, common themes have emerged. The dignity and respect afforded to older people, particularly when they are receiving care, was one of these common themes.

Many stakeholder organisations reinforced this view and this led to the Commissioner's announcement in March 2010 that the Review would focus on dignity and respect in a health setting.

The remit of the Review

We decided this Review would focus on hospital inpatient care because of the strength of concerns expressed about the impact on older people of a poor hospital experience.

An ICM Poll² of 1,500 people of all ages, commissioned by the Older People's Commissioner for Wales found that only 36% of people were confident that an older person would be treated with dignity in hospital. 31% of those polled were not confident an older person would be treated with dignity.

NOTES:

1. Commissioner for Older People in Wales Regulations 2007, Reg. 14(2) (2007/398).
2. Ref: ICM interviewed a sample of 1000 adults in Wales aged 65+ by telephone between 18 - 25 March, 2010. A further 500 adults aged 18-64 were interviewed 14 - 19 April 2010.



Overall 49% of people said that they, or an older person they know, had a positive experience of care in a hospital setting. 21% said they, or an older person they know, had a negative experience.

We also know that people aged over 60, are significant users of hospitals in Wales, accounting for 47% of inpatient admissions in 2009 and 2010.³ We focused the Review on the experiences of older people who were, or had been, hospital inpatients for at least five days within the previous two years.

This reflected concerns about the long term impact of a loss of dignity and respect during sustained or lengthy periods in hospital, rather than during a more transient experience, such as in an emergency or outpatients setting.

There were over 228,000 episodes of an older person spending five or more days in hospital between January 2008 and December 2009.⁴

NOTES:

3. Patient episode database for Wales: date of extraction by Health Solutions Wales 07/02/11
4. Patient episode database for Wales: date of extraction by Health Solutions Wales 28/06/10

Introduction

The recent structural reforms in the health service in Wales also presented opportunities to influence change.

All the newly formed Local Health Boards and one NHS Trust were subject to this Review, namely: Aneurin Bevan Health Board, Abertawe Bro Morgannwg University Health Board, Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board, Cwm Taf Health Board, Hywel Dda Health Board, Powys Teaching Health Board and Velindre NHS Trust. Throughout the report they are collectively referred to as the “Health Boards and the Trust”.

Defining dignity

To define the elements of care which impact on dignity, we have used the framework set out by Help the Aged’s 2007 report **The Challenge of Dignity in Care: Upholding the rights of the individual**.⁵ This identifies personal hygiene, eating and nutrition, privacy, communication, pain, autonomy, personal care, end of life, and social inclusion.

Dignity also consists of many overlapping aspects, involving respect, autonomy and self-worth.

Panel of Inquiry

To secure a robust and detailed evidence base upon which to frame recommendations, the Commissioner appointed a Panel of Inquiry (Appendix 3) to collect evidence of older people’s experiences in hospital and to identify good practice. The Commissioner identified potential Panel members through discussions with key stakeholders and sought a balance of skills and expertise in the following areas: medical, nursing, carer, social services, local health boards, and research.

The Panel commenced its work in June 2010 under the chairmanship of Dame Deirdre Hine.

NOTE:

5. Levenson R (2007) *The Challenge of Dignity in Care: Upholding the Rights of the Individual* London: Help the Aged



Recommendations

Recommendations

Commissioner's Recommendations

The twelve recommendations made in this report have been developed based on the findings of the Panel of Inquiry. A summary of the relevant evidence precedes each detailed recommendation.

Changing the culture of caring for older people in Welsh hospitals

1

Stronger ward leadership is needed to foster a culture of dignity and respect

Making dignity and respect a reality for all older people has to mean the consistent translation of the policies and principles of person centred care into actual good practice at ward level. For all staff, training is key, as is learning from good role models who are delivering dignity and respect. The Panel found that the best examples of excellent care were being delivered in settings where skilled ward managers were demonstrating strong leadership and were equipped with the knowledge and authority to shape the culture on their wards.

Detail of Recommendation 1

Health Boards and the Trust should ensure that the ward managers on every ward in which older people are treated are empowered with the skills and authority to create a culture of dignity and respect. This must include the:

- necessary clinical leadership skills;
- support of specialist consultant nurses especially in dementia care and continence;
- knowledge of the correct staff numbers for their ward;
- authority to select staff;
- authority to ensure that their training needs are met; and
- responsibility for regular appraisal of the skills, knowledge and attitude of the ward staff.

2

Better knowledge of the needs of older people with dementia is needed, together with improved communication, training, support and standards of care

The Panel found that there was general agreement amongst staff that a great deal more needs to be done to improve care for people with dementia. In both acute and community hospitals, concerns were raised about a lack of knowledge of the needs of people with dementia, the levels of training and support available, communications, and standards of care.

For people with dementia, admission to hospital can be a frightening and disorientating experience, and can lead to disturbed behaviour, a higher risk of falls and increased use of sedation. The impact on patients, with or without dementia, being cared for on the same wards can be increased anxiety and distress.

There needs to be much clearer recognition that people with dementia are not an isolated group who somehow sit outside the mainstream of those receiving hospital care; rather, they should be recognised as a significant and increasing group within the hospital population whose care should be proportionate to their needs.

Health Boards and the Trust need to have a focus on service planning, delivery and review.

They also need to attend to the physical environment and staff learning and development. Regular contact and mentoring on the ward from dementia specialist staff is needed.

This Review has included dementia as part of a wider picture. There remains a need for further, more specific examination of dementia care in acute and community hospitals, as well as in specialist mental health facilities.

Our findings give us significant cause for concern about the experiences of older people with dementia in general hospital settings.

Recommendations

Detail of Recommendation 2

Regular dementia awareness training and skills development should be a requirement for all staff caring for older people. Specialist and skilled multi-disciplinary input needs to be available to support staff to deal more effectively with people with dementia. This should include a Consultant Nurse/Clinical Nurse Specialist available to give both case specific advice and to assist with staff learning and development in this area more generally.

The Welsh Assembly Government should commission further work exploring the treatment of, and experience of, people with dementia in hospital, and ways to improve, building on the National Dementia Action Plan for Wales and the associated 1000 Lives Plus work programme. This should bring about better care for older people with dementia in hospitals in Wales.

3 Lack of timely response to continence needs was widely reported and is unacceptable

The Panel's findings highlighted that patients' toileting needs are not always met and that there is merit in the supportive role of the specialist continence advisor to support ward staff. The lack of a prompt response to calls for assistance, failure to prioritise toileting needs in care routines, and an over reliance on pads was found to be resulting in avoidable incontinence. This is unacceptable and should stop. It has a humiliating and degrading effect on older people, is a major source of distress and an assault on their self respect. It is contrary to the spirit of the United Nations (UN) Principles for Older Persons.

Detail of Recommendation 3

Health Boards and the Trust should prioritise the promotion of continence and management of incontinence. They should ensure that staff at all levels are empowered, trained and aware of the impact of both the ageing process and acute health conditions on continence. They should also devise an appropriate method for identifying older people's experience of continence care.

4

The sharing of patients' personal information in the hearing of others should cease wherever possible

When an older person is in hospital the traditional ward round almost inevitably ensures that intimate personal information about their clinical condition and treatment will be heard by other patients and their visitors. This has become almost a given, something which just happens because of the environment in which someone finds themselves. There needs to be much more focus on the rights of patients, as provided for by the Human Rights Act. It is time to challenge existing practice and to raise people's expectations of dignity and privacy during their hospital experience.

Detail of Recommendation 4

Clinical staff should regard their routine review of patients as a series of individual consultations, and whenever possible these should take place in a ward facility which is accessible, appropriate, and offers privacy.

5

Too many older people are still not being discharged in an effective and timely manner and this needs urgent attention

It is vital that the current public finance situation is not allowed to have a negative impact on discharge planning and partnership working, including within and between statutory and third sector organisations. It is a false economy to leave people in hospital and we have to find smarter ways of working in the current budgetary context.

The process of discharging an older person from hospital in an effective and timely way remains problematic and unsatisfactory. This is despite much activity and numerous reports on the issues in Wales. The impact on older people caught up in this process can be disheartening and even debilitating as they can lose significant function, making it much harder to regain an independent life. The system can actually serve to institutionalise older people.

Recommendations



The Panel heard considerable evidence that the process of assessment and discharge is not working effectively. This included accounts of delays in care packages, particularly for those with more complex needs or dementia; cases of inadequate engagement with social services especially for people in hospitals outside their home county; and variation in the level, quality and timeliness of communication about discharge plans.

Discharge planning should be an integral part of the admission procedure so that steps can be taken from the outset to ensure that older people do not languish in hospital when they are clearly well enough to leave. Learning from good practice including effective discharge schemes run by the third sector is important.

Effective discharge planning needs to be driven forward with urgency at a national level by the Welsh Assembly Government and at a local level by Health Boards, the Trust and Local Authorities.

Detail of Recommendation 5

Health Boards, the Trust and Local Authorities should jointly develop more focused and effective commissioning of services and care for older people, including those with dementia, in order to reduce further the level of delayed discharges; and support this work through more robust embedding of Social Services staff in this process through ward level multi-disciplinary teams.

Resourcing the care of older people in Wales

6

The appropriate use of volunteers in hospitals needs further development, learning from successful initiatives

The Panel saw encouraging and inspiring examples of volunteers contributing positively to older people's hospital experience. Health Boards and the Trust should recognise the expertise of the third sector and work with them to realise the potential of appropriate, imaginative use of volunteers. With professional management, good induction and support at ward level, using volunteers can have tangible benefits. It is an area where relatively modest amounts of expenditure can realise benefits of a value far in excess of the funds invested.

Detail of Recommendation 6

Health Boards and the Trust should ensure that their hospitals further develop imaginative volunteer programmes to enhance patient experience, building on existing successful initiatives.

7

Staffing levels have to reflect the needs of older people both now and in the future

In a context of financial constraints, but also of an increasing older population, effective planning of staffing levels is crucial to the success of the health service in Wales. The key issue for public services now is learning to do more with less.

The Panel observed variation in staffing levels and were concerned that ward managers were sometimes unaware of the necessary staffing complements to run their ward appropriately. Amongst many older people and their relatives, there was a perception that staff levels were too low, adversely affecting staff responsiveness and the time available for meaningful interaction with older people.

Recommendations

It is important to acknowledge that it is not just about staff numbers. Even on some very busy wards, the Panel saw how a positive ward culture can result in better outcomes despite limited staff resources. There are established tools for assessing staffing numbers and there must be greater transparency, both throughout the NHS in Wales and amongst the general public, of the appropriate levels of staff needed in our hospitals.

Detail of Recommendation 7

The Welsh Assembly Government, building on existing tools as a guide for determining staffing levels, should develop and implement a tool for Wales to determine both appropriate staffing levels and how staff should be deployed. This work should encompass current and forecast levels of need in relation to the care of older people.

8

Simple and responsive changes to the ward environment can make a big difference

When opportunities arise to undertake the refurbishment, redesign or construction of hospital facilities, they must reflect the preferences and needs of the people who will use or work in them.

This includes the provision of adequate and appropriately located toilet facilities, and a mix of bays and single rooms that reflects expressed preferences of older people.

Change need not involve major construction schemes, but wherever possible opportunities need to be taken to make simple changes such as clearer signage and use of colour, to improve existing wards for the benefit of all, especially patients with dementia.

Detail of Recommendation 8

The Health Boards and the Trust should, in collaboration with older people and their families and carers, make changes to ward layout which are most beneficial. This is to ensure all patients have satisfactory access to ward facilities.

The Health Boards and the Trust should work together to devise and adopt an inclusive consultation process with patients, their families and carers and a representative mix of staff of all grades and across all roles that takes account of the principles of good design when refurbishing or building hospital facilities. The needs of those with sensory loss or dementia should be central to this process.

Creating the conditions for greater dignity and respect in hospital care

9

Effective communication can raise patient expectation and involvement and can improve their hospital experience

Older people and their relatives and carers demonstrated in their evidence to the Panel that they understand and empathise with workloads of hospital staff. Yet they did not show a similar level of understanding or demanding of their rights, nor did they have high expectations of how they should be treated.

Hospitals need to make clear to older people, their families and carers, what they should expect in relation to the quality of their care, including how staff will respect their dignity and rights. The way in which staff communicate and involve people in decisions should, from admission onwards, positively reinforce a person's expectations of quality care.

Support needs to be made available, including the provision of equipment to aid those with sensory impairment, and through the provision of advocacy for those who need it, so their voices can be heard and their experiences captured.

Recommendations

Detail of Recommendation 9

The Health Boards and the Trust should provide older people, their families and carers, with a clear explanation of their right to receive good quality, dignified care. This must take careful account of sensory loss or other barriers to effective communication. Staff should maintain standards of communication and involvement which reinforce dignified care.

10 **The experience of older patients, their families and carers should be captured more effectively and used to drive improvements in care**

The need to be more responsive to the individual requirements of older people in hospital is a cross-cutting theme in our report. We have found significant cause for concern in, for example, the areas of continence care, assistance with eating and drinking, communication and arrangements for discharge. We have also found that there is considerable variation in the quality of care across Wales and even within the same hospital. We did find examples of very good practice. However, in other areas, standards of care must be raised to meet that of the very best wards and hospitals.

Knowledge of the experience of older people in hospital and whether they are treated with dignity and respect is essential in order to help drive change, to identify good and poor practice, to determine progress, and to assist learning and improvement across the NHS. We found that the current arrangements for capturing the experiences of patients were not sufficient to allow their voices to be heard; they do not collect adequate numbers for robust analysis, or allow for comparison between organisations. This has implications for considering experiences of patients in general, but as noted elsewhere, the majority of patients are older people.

There should not be a reliance on complaints as the main means of understanding the patient experience. Many people are either reluctant to complain, cannot complain because of their illness, or do not have relatives or carers to advocate on their behalf. We recognise that there are efforts being made in some places to collect patient experience data, but more needs to be done.

Detail of Recommendation 10

The Welsh Assembly Government should lead on, develop and implement a clear, consistent mechanism through which Health Boards and the Trust will capture and act on the experiences of older patients, including those unable to speak for themselves.

This mechanism would allow qualitative data about older people's experience to be captured, understood and used to drive organisational learning and positive change. Results should be made publicly available in a form allowing ease of understanding and comparisons over time, on a Wales-wide and on a Health Board and Trust basis.

Health Boards and the Trust must demonstrate, for example, through Board meeting records, how they have taken account of and acted on, their patient experience results. Board members should also play a direct role in assessing the patient experience through means that include regular ward visits to both speak to patients and their families and observe care delivery.

11

Good practice should be better identified, evaluated and learnt from to bring about improvements in care

Health Boards, the Trust and staff at ward level need to take responsibility for identifying, sharing, assessing good practice and building their services based on what is shown to work. The Welsh Assembly Government has an important role in ensuring the effective dissemination and uptake of good practice.

We recognise that progress has been made through a number of existing mechanisms including the National Leadership Innovation Agency for Healthcare, Good Practice Wales web portal, and the Social Services Improvement Agency.

Recommendations

Detail of Recommendation 11

The Welsh Assembly Government should drive forward the evaluation and adoption of good practice across Wales, with an emphasis on securing positive, demonstrable changes in practice in the care of older people. The Welsh Assembly Government should hold the Health Boards and the Trust to account for their success in adopting good practice which enhances dignified care, or justifying why they have not done so.

12 All those working with older people in hospitals in Wales should have appropriate levels of knowledge and skill

The Panel expressed concern that the ageing process and the implications for older people and their care, are not well enough understood by all staff. Skills development in caring for older people, including communication skills, was not as evident as it needs to be if current or projected needs are to be met.

Detail of Recommendation 12

The Welsh Assembly Government, Health Boards and the Trust should ensure that all staff caring for older patients acquire appropriate levels of knowledge and skill through continuing education and training.

The Welsh Assembly Government should ensure opportunities for those with high levels of training to specialise through a career framework appropriate for current and future need.

Panel's Findings



Inquiry Panel's Findings

Hospital Review Timeline

- **April 2008 - January 2010**
The Commissioner speaks to older people throughout Wales and gathers their views and priorities.
- **February 2010**
Consultation on whether the focus for the Commissioner's first Review should be social care or health.
- **March 2010**
The Commissioner announces that the Review would focus on dignity and respect in a health setting.
- **April 2010**
The Panel of Inquiry is appointed.
- **May - June 2010**
The Panel of Inquiry established the scope of the Review and the methods they would use to gather evidence.
- **June - August 2010**
Public call for evidence about older people's hospital experiences.
- **September - November 2010**
The Panel conduct visits at sixteen hospitals throughout Wales.
- **December 2010 - January 2011**
The Panel analyse the evidence and prepare the report of their findings.
- **February - March 2011**
The Commissioner considers the Panel's findings, and develops the recommendations.
- **March 14, 2011**
Publication of the Review report and recommendations.
- **June 14, 2011**
Deadline for responses to recommendations. The public bodies to whom recommendations are directed have three months to respond and demonstrate to the Commissioner what further action they will take to comply with the recommendations.
- **June - October 2011**
The Commissioner will keep a register containing details of the recommendations and further action taken. The Commissioner can take further action to follow up the responses to the recommendations.

The Inquiry Panel's Findings

The UN Principles for Older Persons underpin all the work of the Older People's Commissioner for Wales (Appendix 1). The Principles state that older people should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

All these were issues raised with us through the evidence we received.

The strength of our findings is based upon the centrality given to the voices of older people, their families, carers and fellow patients. Our findings reflect the voices of those who chose to engage with us. We must value these voices and give due regard to the issues they raise. We have based our judgement as a Panel on what has been brought to our attention through our call for evidence and hospital visits and the implications for what needs to happen next.

Details of how we collected our evidence can be found in Appendix 3. The quotes used throughout our findings have been taken from written evidence or from conversations during our hospital visits.

1. Ward environment

The ward environment shapes an older person's experience in hospital in ways which should not be underestimated. From the physical layout of bed spaces, to the location and availability of bathrooms, the environment has a profound impact on the dignity afforded to people in their day to day care.

■ Ward facilities and design

Many hospitals, particularly community hospitals, are not purpose built for meeting the needs of older people in the twenty first century, often consisting of ageing buildings that are difficult to modify. In many of the older hospitals we visited the "lovely," "welcoming" atmosphere and "excellent" staff some older people spoke of was achieved despite, rather than because of, the physical environment.

Inquiry Panel's Findings

Throughout the evidence, references were made to cramped conditions on the wards, to the inconvenient location and inadequate availability of bathroom and shower facilities, and to people being too cold or too warm on the wards, particularly at night:

“The ward was very cold, so cold that he had to wear a bobble hat and on one occasion, telephoned his son at 3am to ask for a duvet to brought to the hospital.” (Relative)

“We were shocked to find that, due to lack of room they had put her in a large room at the end of the corridor which was an old six bed ward that was now being used for storage of old furniture etc. and the only bed was hers, without a table or cabinet. She was quite upset and didn't want to stay there on her own, but due to her loss of speech was unable to communicate this to staff.” (Relative)

We did not see evidence that ward environments catered for the needs of people with dementia. These patients are becoming a significant proportion of admissions to acute hospital wards. This issue is covered in more detail in our section on dementia.

Another common feature of our visits to the wards was the underused and often neglected dayroom. In many cases, these rooms had decor which was plain or dated, and contained little by way of entertainment which would attract people away from their bed. Instead, these rooms were used mainly as additional storage space for supplies and medical equipment.

Sometimes they were utilised by occupational therapists or physiotherapists, and some wards encouraged patients to take their lunch communally in the dayroom, but such examples were in the minority. The written evidence we received did not suggest widespread use of dayrooms, supporting instead the notion that people relied on resources and activity in their bay or room.

It was striking how accepting older people were of their physical environment, with little aspiration or expectation that changes would be made.

Staff also recognised that the nature of the ward layout underlies many of the difficulties they face on a daily basis when trying to provide dignified and appropriate standards of care:

“We are concerned about the ward layout and the problem this causes with the use of toilets and bathrooms. We hope this will soon be addressed when the refurbishment takes place.” (Staff)

“The ward environment is not great with some rather cramped bed spaces and with the curtains not providing enough privacy.” (Staff)

Newly built or refurbished facilities generally have better provision to make separation of the sexes easier and the more modern hospitals we visited had, through design, strived to address some of the barriers to dignified care, such as space and privacy. We also saw several hospitals in which redesign or refurbishment was planned, and there will inevitably be constraints on this process, both financial and from the physical space available. Imaginative ways need to be found to make the best use of what exists, and to achieve the potential offered by change.

Disappointingly, where improvements or hospital redesign were being carried out, we saw limited evidence of patient involvement or consultation. Some staff were involved in decisions about redesign or new build, but in the case of one planned refurbishment, we heard from staff in non-nursing professions that they had not been asked about their requirements in the new environment.

Health Boards and the Trust should proactively involve both clinical and non-clinical staff, patients and their representatives in decisions about redesign and new build.

■ **Single rooms and shared bays**

Being located close to other patients on the ward brings both advantages and disadvantages.

Despite problems with privacy, many of the older people we spoke with said they preferred being in a shared bay to being in a single room. There was a notable sense of camaraderie with phrases

Inquiry Panel's Findings

like “we look out for each other” and “we help each other” used frequently during our interviews.

People described using the buzzer to call for assistance on each others' behalf when someone was in difficulty, and that this gave them an increased sense of safety. The immediate proximity of others also helped ease their boredom. In their written submission, one older person stressed the importance of this social interaction:

“It is also worth noting that when in hospital a bond is created between patients and from that bond support is formed which helps bolster an older person’s confidence dignity and self respect.” (Patient)

This appreciation of others' company while in hospital can be affected, however, by the presence of an agitated person on the ward (usually a person with dementia). A number of patients commented that when they felt tired or unwell, the presence of a restless or distressed patient was very unsettling.

This highlights why ward facilities must be appropriate for different patient groups, including those with dementia. Ward leadership is key here as staff need to have the flexibility and the authority to use the ward space to the benefit of the patients, meeting their preferences when possible.

Staff often mentioned the merits of single rooms for privacy and infection control, as did some of the older people in such rooms who were clearly content to have their own space. However, many older people also expressed concern about the isolation and boredom which can result from separation in single-bedded units.

It is apparent that there are conflicting perspectives. In their evidence, the Royal College of Nursing suggested there was a difference between generations, with younger patients prioritising privacy and therefore keener on single rooms. This is an area which would merit further exploration, particularly considering the impact of both settings on a person's wellbeing and recovery.

The variance of opinion we found reinforces the importance of consultation with patients before refurbishment or construction projects are undertaken.

Where hospitals are designed with an emphasis on single rooms, there must be appropriate staffing complements because, unless such wards are staffed more generously than conventional wards, there is a danger that patient supervision may be inadequate and older people may feel abandoned.

We do not subscribe to the view that the move towards single room only wards is reflective of the preferences or needs of the majority of older people.

■ Mixed sex wards

All the evidence we received reinforces the view that mixed sex wards are disliked and are a source of distress.

There are difficulties of definition to be addressed when considering the issue of mixed sex wards. We acknowledge that in some environments - such as Emergency Admissions or Accident and Emergency departments, full segregation of the sexes would be unrealistic from a practical and financial viewpoint. We did not visit mixed sex wards in the sense that male and female patients were in beds adjacent to one another.

We visited wards which contained single sex bays within a mixed sex environment. In their evidence to us, all of the Health Boards reported their efforts to adapt existing buildings to ensure - wherever possible - patients are nursed in single sex bays. It is sometimes more difficult to ensure that each bay is located next to toilets for the same gender.



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Our observations were that bays were rightly used flexibly, and their designation as male or female was dependent on the profile of admissions at any one time. However, as a consequence of this, repeated re-designation of bays means the location of the single-sex toilets and bathrooms is prone to change.

While each Board told us they seek to ensure that facilities are clearly labelled, the physical distance between bay and bathroom is one of the major affronts to people's dignity, illustrated by an experience shared by one relative:

“The bay next to (her) had male occupants and the only resulting problem with that was that the toilets and bathrooms were on the other side of the corridor; patients having to be taken across and along the corridor in view of patients in other bays. Sometimes these were wearing hospital type gowns - and were an embarrassment to beholder and wearer alike.” (Relative)

In their evidence, the Royal College of Nursing called for the abolition of mixed sex wards as a priority, highlighting the particular problem in which dementia leads to uninhibited behaviour and aggression. For new build projects and refurbishment projects, the ideal solution, along with a mix of single rooms, is the provision of en-suite bathroom and toilet facilities in each four or six bedded bay. We received some evidence that this has happened in some Health Boards.

■ Privacy

Privacy is about having private space, about being apart from others and free from observation, intrusion or attention. In hospital it is also about being covered appropriately and not exposed in a personally embarrassing way while being cared for.

Disappointingly, the layout of hospital wards imposes a lack of privacy in many instances, particularly as in the majority of cases, staff are dependent on the use of curtains. It is not acceptable that people's privacy is lost as a consequence of their location on a ward.

In multi-bed bays, people are often faced with situations where their privacy is compromised. The evidence we gathered reflected a range of experiences, concerns, and efforts by staff to mitigate the impacts of the physical environment.

Most older people who gave us evidence were accepting of, or resigned to, a lack of privacy. This underlying acceptance was most obvious during our hospital visits when relatively little concern was expressed by patients at the loss of privacy on the ward.

Many viewed it as an inevitable part of being in hospital:

“You do lose a bit of privacy in a ward like this but it’s not a problem.” (Patient)

As mentioned previously, the majority of older people we spoke with preferred a bay rather than single room accommodation, in which, despite the limitations on their privacy, they felt safer, valued the social interaction and often formed friendships with other patients.

From written accounts, we heard about the impact of a loss of privacy on some individuals and their families. Some older people wrote of their discomfort when being cared for or using a commode on the ward, knowing there were other patients and visitors just behind the curtains:

“I was uncomfortable when there were day time visitors to adjacent beds behind the privacy curtain during examinations, dressing change times, and during ablutions.” (Patient)

While some older people recognised the limitations of curtains, some also praised staff for making good use of the curtains as a matter of routine:

“At the slightest sign of distress by any patient, such as coughing, nurses always pulled the curtains around the bed for privacy.” (Relative)

In the written evidence, acts of omission by staff were shown to compromise dignity and privacy. Examples were given of individuals being inappropriately covered while on the ward or while being moved:

Inquiry Panel's Findings



“...it was necessary for my mother to be transported by commode chair to the toilet. She was wheeled from the ward by staff... her modesty was compromised until my wife intervened and caused her lower body to be covered by a blanket.” (Relative)

There is undoubtedly much work underway to secure privacy for patients, for example we saw several systems in use which are designed to protect people’s privacy on the ward. Additionally, Health Boards shared the results of their Fundamentals of Care audits with us, which generally showed a high level of compliance with standards related to dignity.

One hospital was trialling the use of solid screens around the bed, others used visual prompts. We saw a system based on traffic lights which guided staff as to whether it was appropriate for them to enter a curtained area or single room where a patient may be receiving personal nursing care. There were variations on this concept, including using ‘care in progress’ style notices, pegged to curtains. Further details of such examples of good practice can be found in Appendix 9.

We support these initiatives as examples of good practice because they allow patients and staff to feel confident about the environment in which care is provided. It was also evident that both from the patient’s reports and from observation on the various wards that these initiatives have produced an environment in which patients are treated with empathy and respect as individuals.

Our evidence showed that while things are moving in the right direction in some areas, there is still some way to go. People in hospital need to raise their expectations and assert their right to privacy. Health Boards and the Trust need to consider making changes to the ward environment and methods of care need to adapt if that privacy is to be made a reality. Where patients are not severely ill or immobile the individual consultation should be conducted in a private space. Where this is not practically possible, staff should make every effort to ensure that their duty to ensure patient confidentiality is being discharged.

■ Cleanliness

We were impressed with the attention to cleaning and hygiene practices in the hospitals we visited and the results were obvious. A strong focus on infection control was very evident and appeared to be having a positive impact at the ward level.

The older people we heard from were generally happy with the cleanliness of their environment and complimentary about the cleaning staff:

“...they are obviously recruiting the right ones to come to work here. Yes, the cleaner is very good and has a chat with you as she goes about her work.” (Patient)

“The ward was immaculately clean.” (Patient)

Ward routines supporting high cleanliness standards were observed during some visits. In one example, weekly deep cleans of bays was achieved by moving all patients, in their beds if necessary, to the dayroom where they had access to the television and magazines. This allowed cleaning staff the space and access necessary to thoroughly clean all surfaces and equipment. This had made a positive impression with patients even though they had to be relocated while cleaning took place.

While there was praise for high standards, we also received written accounts highlighting that problems remain. Often bathrooms were mentioned as falling short of acceptable standards, but there were also accounts of medical waste not being cleared after treatment, or areas under and around the beds not being cleaned. Carers Wales told of their survey finding that the “majority” of carers they surveyed

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had negative accounts of hospital cleanliness. In some cases, this contrast was reported between hospitals in the same Health Board area:

“Standards of cleanliness left a lot to be desired. I washed her locker every day myself. When she had been there a week, I found a dirty shoe covered in dust under her bed.”
(Relative)

“There was a high standard in cleaning/disinfecting beds and commodes which was very reassuring.” (Relative)

On balance, we feel standards of cleanliness have significantly improved over recent years. This is proof of what can be achieved when there is a concerted effort by all staff to tackle a widespread and difficult problem. There are lessons to be learnt from this area of progress in tackling other issues in the NHS in Wales.

2. Interpersonal care

■ Personal care and hygiene

Basic standards of care are key to the hospital experience. We found in evidence from individuals, organisations and our hospital visits examples of unacceptable care which seriously impact on patient identity and fail to respect their dignity.

There was overwhelming recognition by older people of the impact that time constraints had on the ability of staff to respond to their needs effectively and in a timely fashion. Some applauded the creativity of staff despite these constraints.

Visitors that we spoke with also highlighted that while the level of care was very good on the ward, they felt that perceived staff shortages impacted on the staff's ability to deal with the everyday demands of patients. They would like the staff to have more time to spend with the patients, to talk to them more, and look after their basic needs.

“I did not or any other member of the family in the five weeks see the staff make conversation or reassure the elderly patients or treat them as if they were real people in their own right, they were treated and spoken about as bay and bed numbers.” (Relative)

While the majority said that they experienced no problems using their buzzer, others identified problems especially in staff responding to buzzer calls. Problems ranged from a lack of buzzers, a lack of prompt response and even instances where buzzers were placed out of people's reach. Many older people believed delays in response were due to shortages of staff.

In some instances, the lack of responsiveness to the buzzer was made worse by a perception that key staff were located at stations too remote from the patients, or were ignoring patients:

“She was in pain and pressing the bell, was ignored and I had to walk twice to the nursing bay before I got any help. She was having a massive heart attack...” (Relative)

“He felt sick and called for the nurse to bring a sick bowl. It took half an hour for the nurse to arrive but by that time he had been sick all over himself.” (Patient)

“...the loss of a nurses station in the open ward means less general realisation of patient needs. Groups of nurses in the ward office and kitchen enjoying a chat whilst patients needs are not being met. It should not be necessary for a visitor to chase nurses to get attention for a patient.” (Patient)

■ **Continence management**

The Health Board evidence confirmed that they have procedures for the assessment of patient continence on admission.

The management of continence was, however, the subject of a lot of mainly negative comment from older people across Wales, and it is undoubtedly a matter of great significance. There is a consistency in the nature of the concerns raised: timely assistance with toileting, avoidable incontinence and inappropriate use of continence pads were mentioned by a significant number of people.



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As with the issue of cleanliness, the written evidence reflects differing experiences even within the same hospital.

Some responses relate to patients being told to use their pads instead of being assisted on request to use the toilet, with the suggestion that this suited the staff's routines.

“While normally continent at home, where she would deal with her own toilet needs, the hospital staff were padding her.” (Relative)

Some references were also made to inappropriate catheterisation as another means of managing continence. Many were concerned at the lack of response by staff when patients indicated they wanted to be taken to the toilet and the regularity with which patients were checked and pads changed:

“Sometimes having to wait too long for staff to take you to the toilet. This has led to accidents happening... Sometimes have to wait up to half an hour and this has caused me problems and me becoming incontinent.” (Patient)

“When asked if her pad could be changed as it was wet we were told that they could only change them after they have been wet five times as they were very expensive and were designed for this.” (Relative)

Some visitors often found their relatives in a soiled state and would take on toileting duties while on the ward. Others witnessed falls as a result of a patient trying to reach a commode or toilet, unassisted, in order to avoid being incontinent. Other responses refer to patients self-limiting their fluid intake to minimise the possibility of being incontinent.

One patient told us that he dirtied himself due to having loose motion and the staff were not able to take him to the toilet although he had rung the bell 10 - 15 minutes earlier. He felt very embarrassed about the incident. There were however examples of praise:

“I started going to the bathroom on my own, they would leave you so that you had your privacy and then as soon as you pulled the cord they would come back.” (Patient)

“I was impressed by the care given. Pads were changed regularly and discreetly.” (Relative)

Responding to continence needs of patients should be prioritised by all staff, to avoid the humiliation and degradation of the patient.

■ Personal care

Evidence from the Health Boards generally reported high levels of compliance in audits of personal hygiene, and established procedures for identifying personal care needs on admission; particular issues such as oral hygiene and foot care have, however, caused problems in some areas.

Many staff told us of the constant pressures they are under to meet the clinical and personal care needs of patients. By and large patients recognize this pressure and compliment staff on their efforts on their behalf, but it is often personal care that suffers when workload is particularly heavy.

We received some evidence that insufficient attention was being given to managing patients' washing and personal care needs. Several people referred to bowls of water being left on lockers for patients to wash themselves, even when they were physically unable to.

Several relatives told us they had to take home heavily soiled, possibly infectious, laundry. This was also featured in the evidence given by organisations who said that some patients have been told that the hospital does not have facilities to wash patients' soiled clothing. Relatives and carers are expected to take such clothing home with them, sometimes on public transport.

“Despite my mother-in-law being infectious the family were told to take her laundry home to wash, this seemed at odds with trying to prevent spread of infection.” (Relative)

One relative told us they found a soiled incontinence pad and a bottle of medication mixed in with the laundry they had taken home to wash. We received several accounts of relatives having to make repeated requests to staff for their family members to be changed into clean nightwear, despite the availability of clean items in their lockers.

Patients should be given assistance in the appropriate laundering and provision of regular changes of clothing and toiletries, and this should be part of the daily culture of the ward.

Inquiry Panel's Findings

Lack of care for dentures and teeth, hair, and basic nail-cutting also featured in our evidence.

“Her false teeth have never been put in to soak and are consequently foul tasting and soiled. Likewise her hair has become tangled and knotted from time to time. Her toe nails are overgrown and every time I have enquired about having them cut I am told they (the staff) are not allowed to cut them but she will be put on a referral list.” (Relative)

■ Other services

Older people often spoke of the sort of services that they felt should be considered as a requirement for daily living but which are not routinely encouraged within hospitals.

While it may be thought that some of these services may not be directly linked to any physical health needs of older patients, it is important that their psychological, spiritual and social needs are met.

For example, hair styling, foot care, and nail care are often not available for patients on the wards. Age Cymru's campaign for effective foot care services for older people in Wales, 'Little steps can make a big difference', highlighted that foot care is a vital service for many older people, preventing falls and important for mobility and independence.

There has been discussion about the relative roles of nurses and assistants. However, at all levels of nursing, staff must be prepared to respond in a timely fashion to the most basic care needs of patients and do so with sensitivity and compassion. Crucially, they must be responsive to continence needs which if not handled well, are so distressing for older people.

Personal hygiene is a major element in older people's feelings of self respect and must therefore be a priority for caring staff. The evidence we received about problems with washing, oral hygiene and ensuring clean nightwear is available indicate these matters are not being given the attention they deserve. Despite the busyness of wards, we have seen examples of very good care, particularly where strong ward leadership was evident.

3. Communications

Effective communication is an integral part of good quality health care and is not an optional extra. It is a two way process that should take into account an individual's needs and any sensory or cognitive impairment.

Older people, and where appropriate their relatives and carers, should be involved in discussions and decisions at all stages of their hospital care. Their involvement should start at the earliest possible stage and enable them to exercise informed choices during their stay in hospital and to secure the additional support they need after discharge.

■ Confidential communication

Staff are entrusted with personal and intimate details of a person's condition.

To preserve the private nature of such information, the environment in which it is discussed must support confidentiality. We found, however, that confidential environments are not the norm and a lot of people lack privacy and confidentiality during discussions about their personal circumstances and condition. This is not acceptable. For many older people and their families this is a clear example of dignity being compromised:

“One time I visited my father and heard the medical staff convey bad news to the patient in the next bed about his diagnosis. I felt that the dignity and respect of that patient had been violated.” (Relative)



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While curtains are often being used to try to provide privacy, the inadequacy of these as sound barriers was frequently mentioned by staff, older people and family members:

“Privacy within the bay was only visual, curtains used to mask events but do not hide the spoken word which came across loud and clear to all within the bay.” (Relative)

While acknowledging that not all wards have such facilities, we observed many underutilised dayrooms which have the potential to offer a private environment in which confidential discussions can take place. Similarly ward offices could provide private space when needed.

If an older person has a degree of hearing loss, the impact on their dignity of a lack of privacy and confidentiality can be even more pronounced. Early recognition of a patient's hearing impairment and the appropriate provision of amplification equipment would prevent staff from finding a need to speak loudly and further compromise the patient's confidentiality:

“Because of her deafness, all conversation with (her) was audible to everyone else on the ward. (She) told me that she felt ‘humiliated’ in front of other patients.” (Relative)

The written evidence provided an example of good practice in offering confidential discussions. For the family involved, their appreciation of the way their situation was handled was evident:

“The consultant and his team explained the situation to us in a separate quiet room, in a clear dignified way, taking time to make sure our questions were answered and our worries and thoughts listened to and understood. The team... should be acknowledged for their positive caring attitude to the patient and family at a very difficult and upsetting time.” (Relative)

In contrasting the hospital experience to the working practices of social work professionals (who conduct sensitive conversations only in a confidential setting), we have concluded that, despite the championing of patient centred care in Wales, the conduct of the ward round remains focused on the convenience of the professionals, not on the needs of the patient.

On occasion there will be practical difficulties for staff on acute wards where the condition of the patient may make moving them difficult. However such challenges are not insurmountable and hospitals must consider more carefully how they can respect people's right to confidentiality. The NHS in Wales must address this serious deficit in their systems and structures.

There are particular practical consequences here for clinicians conducting ward rounds. As a first step, if such rounds are viewed as a series of individual consultations instead, there may be a greater willingness to draw distinctions between routine checks and more sensitive conversations. When staff are imparting potentially life changing and distressing news to patients it is unacceptable to do so in an environment which offers no privacy.

■ **Effective and appropriate communication**

In their evidence, older people, their relatives and carers emphasised the value they place on effective and appropriate communication which enables them to be involved in decision making. Indeed some people responded to the call for evidence purely to offer praise, one older person said:

“...the nurses and doctors were so polite and spent time talking to me. They offered me choices and listened to me. They treated me as a person and not just as a patient.”

(Patient)

In contrast, some older people did not feel involved in planning their care and were unaware of any care plan or even what it might contain. Others told us of instances in which poor communication resulted in confusion and fear:

“I don't know why I am here. I don't know what is wrong with me or what they are doing about it. I don't know when I will be able to go home. I feel trapped.” (Patient)

“I want someone to sit down and tell me what has happened to me and what they can do about it... I didn't have enough information to make decisions... No I don't know what is happening.” (Patient)

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Contrasting practice was especially stark at times when staff were involved in sensitive and time limited conversations with patients and their relatives, such as the placement of 'Do Not Resuscitate' (DNR) notices.

As a matter of right, the application of DNR notices should be discussed with the patient and/or their family members or carers. We heard that this does happen, sensitively and appropriately, with one member of staff commended for being:

"...outstanding in his compassion and communication."
(Relative)

Yet we also received worrying evidence of poor practice:

- a 'DNR' notice placed on a patient's notes without prior discussion with the patient or family member;
- staff communicating with each other about the application of 'DNR' notices around an older person's bed without involving the older person in the conversation;
- the wishes of the individual in the final stages of life not being taken into account.

There is absolutely no room for clumsiness or arrogance in the way that sensitive information of this kind is communicated.

There were many initiatives mentioned by Health Boards which aim to increase patient involvement in their care, and to try to capture patient opinion, but our evidence points to a lack of consistency in

the involvement of older people, their relatives and carers, in both decisions and discussions about care.

Health Boards and the Trust need to make sure that older people are communicated with effectively at all stages of their treatment and that they are aware of their right to share in conversations and make choices. Effective ward leadership and a positive ward culture is vital. The Health Boards and the Trust have an important role to play in raising expectations amongst all those who use their services.

Staff demeanour and ward culture play an important part in shaping an older person's attitude to their stay and in aiding their recovery. An older person's arrival on a ward can set the tone for the rest of their stay, and being addressed in an appropriate manner from the start is important. From our observations we feel significant progress has been made in ensuring that staff ask patients for their preferred form of address, but there is not yet consistency in how these wishes are respected.

Our evidence did highlight the different views between those that value the informality involved in being called by their first name and those that consider this disrespectful, but staff have to be able to adapt and focus on the individual patient's wishes.

“They are called by their Christian names... a familiarity that is neither wanted nor invited by many.” (Relative)

“I was able to enjoy a friendly first name relationship with the regular staff. This informality I found to be relaxing and beneficial to morale.” (Patient)

“Almost the first question when I arrived on the ward was, how did I want to be addressed... and that was how I was addressed throughout my stay.” (Patient)

“Our mother is never asked how she wishes to be addressed and although we always inform the nursing and medical staff that she doesn't respond to Elizabeth as she has been called Betty all her life...” (Relative)

Staff should not assume patients wish to be addressed informally on admission and therefore should address the patient by title until they are settled in the ward and get to know the staff. Strong ward leadership should ensure this is the case.

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We heard much praise for the way most staff engaged with patients. Many older people commented that they had been dealt with appropriately and no differently on account of their age:

“I was never talked down to and everything was fully explained.” (Patient)

“I have no complaints at all about my treatment, the nurses were so busy, but always had time to talk to me, which helped a lot.” (Patient)

“They are all pleasant and cheerful... Even the tea lady is cheerful... The cleaner is very good and has a chat with you as she goes about her work... Here is as close to perfect as you can get.” (Patient)

However, others felt that the way in which they were spoken to did not add to their feelings of self worth and dignity. When this happened, they felt child-like, disrespected and upset:

“She was a bright intelligent lady who was treated and spoken to like a child or just ignored which really annoyed her, she knew she was fobbed off with excuses every day and spoken down to.” (Relative)

“She leant forward only inches from my mother’s face and said in an inappropriate tone, “listen love, I have 38 other patients to see to, you’ll have to wait.” (Relative)

“I was fast asleep in my single room when, at 12.35am, the lights went on and someone shouted my name. It was a nurse who then yelled at me to pack immediately as I was being moved to another ward. I was totally shocked and disorientated.” (Relative)

In one case, a terminally ill patient was talked to by a nurse in a wholly inappropriate way about her state of undress. For the person who witnessed it, and described it as a ‘comedy routine’, it left an indelible impression:

“Unfortunately that lovely, quiet gentle lady who couldn’t speak or toilet herself died that night and rather than soft, gentle, caring words, those were the last words she heard.” (Patient)

Some people complained about staff talking inappropriately about patients within earshot:

“On this ward there was a woman making noises as if in pain, the nurses were doing impressions of her and laughing.” (Relative)



Depending on the hospital setting, a broad distinction emerged in people’s experiences of communication and involvement. The experiences of patients in Community hospitals were generally more positive than those of a District General hospital. Often it was the continuity and familiarity of staff, and a perception that staff had more time to develop a rapport with patients, making the stay in the community setting more positive. Effective communication may indeed pose more of a challenge in busy acute wards, but this requires acknowledgement and even greater efforts by staff to ensure it takes place.

We heard evidence of variation in cultures between shifts and wards in the same hospital. The nature of the leadership at ward manager level has an obvious bearing on the prevailing culture of the ward:

“Some wards are stretched for staff yet the atmosphere is still one of helpfulness on the whole. Other wards leave the impression of having staff that appear to limp from break to break and woe betide those that inconvenience them.” (Organisation)

“In the first hospital, in the recovery ward... Staff gave personal care on all levels and responded promptly to any questions or concerns. In the second hospital, I hardly saw any genuine care and emotional support shown by staff... Did not see any staff pull out a chair and sit with patients for two minutes to offer support, patients regularly calling out/shouting at staff and not being attended to...” (Relative)

Both older people and staff expressed a sense that staff lacked time to get to know patients. As a result, while some patients expressed appreciation of efforts made to meet their needs, others moderated

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their expectations of staff or noted how a lack of time was impacting on the quality of communication.

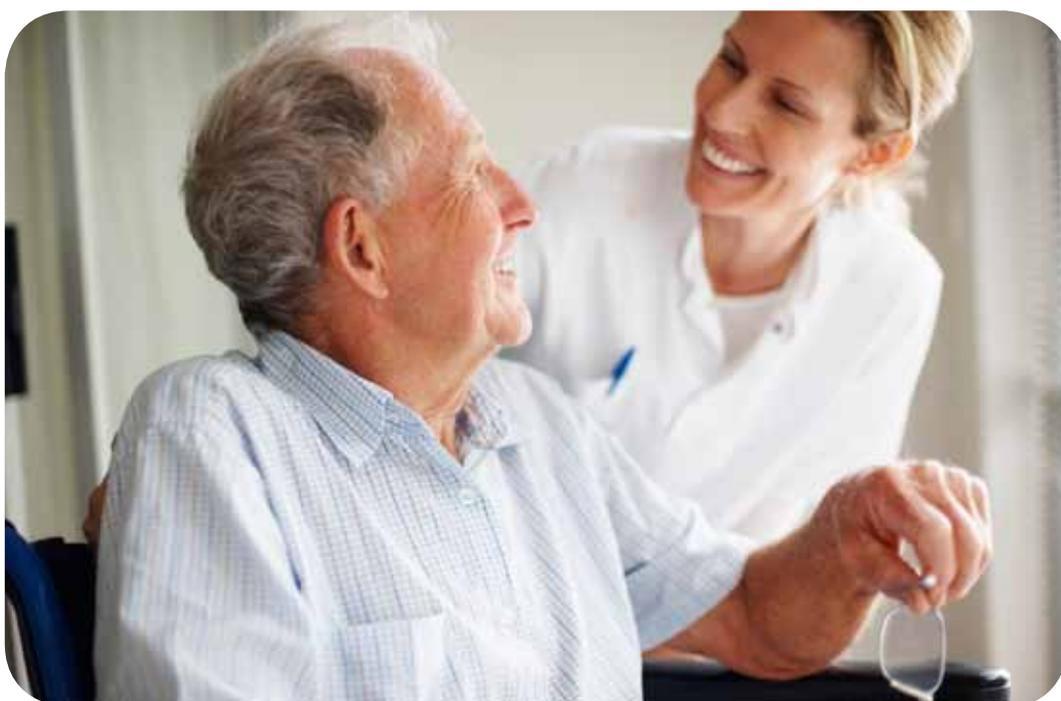
“I would like them to spend a little more time talking to me explaining in detail about my condition but they are so busy they find it difficult to allocate any time.” (Patient)

Some relatives expressed frustration at having to repeatedly relay key information about their relation when that person was moved to another ward:

“We gave a written note of my father’s needs and how his dementia affects his abilities to cope in the hospital environment to staff on the first, second and third wards he was admitted to. It was rarely passed on even to staff on the same wards, let alone when he was moved.” (Relative)

This points to inadequacies in record keeping and in the availability of that information to all staff. Health services should work on the principle that information about a patient’s condition and preferences should only need to be relayed once during each hospital stay and those preferences should be adhered to automatically unless the patient or their family, carer or advocate wishes to instigate a change.

Moving wards is a common experience for many older patients and often induces stress and disorientation – maintaining continuity in meeting patient preferences is therefore especially important in



enabling the patient to settle in to her/his new environment. The clinical record, whether paper based or electronic, should be fully completed and accessible to staff, and moved with the patient to each clinical setting. This is particularly important for patients with dementia or confusion who may be unable to communicate for themselves, and for whom the availability of advocacy or support for meeting their needs is vital.

4. Language preferences

■ Welsh language

The extent to which an older person is enabled to use their preferred language when in hospital is an important issue, particularly when some older people experiencing certain conditions, such as dementia, will revert exclusively to their preferred language.

We heard of a number of concerns about a lack of dignity and respect linked to people being unable to receive a service in Welsh. Many first language Welsh speakers, who are also fluent in English, have a strong preference to speak in Welsh when discussing their emotional wellbeing and pain management, especially in settings where they feel vulnerable. Greater specialisation within hospitals also means people have to travel further from predominantly Welsh speaking areas to hospitals where there might be a paucity of Welsh speaking staff.

“There wasn’t an opportunity to speak Welsh as I couldn’t communicate with the staff as they spoke English, there was no room for negotiation in regards to communication.”

(Patient)

“In the last bed opposite me was a man in his late eighties... who was only able to speak and understand Welsh in his trauma. He frequently misunderstood what was said to him... (by the English speaking nurse)... they didn’t understand each other.” (Patient)

Another first language Welsh speaking older person was communicated with in the early hours of the morning about the imminent death of her loved one by someone whose command of English was poor - she maintained that information conveyed at such a difficult time should have been relayed in Welsh.

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Staff need to be aware that issues relating to the use of Welsh are treated as a matter of rights and not as a luxury on the basis that most Welsh speakers can communicate in English. One English speaking patient in hospital in a predominantly Welsh speaking area stated that she was uncomfortable and unsettled when staff tending her spoke to each other in Welsh around her bed. Given her potential vulnerability, she feared that staff might be talking about her circumstances. When staff are involved in directly attending to the care of a patient it is good practice to make every effort to converse in the preferred language of the patient. This should not imply that the rights of staff to converse in Welsh with each other and other patients should be compromised more generally.

Welsh Language Board Schemes to encourage Welsh speaking staff to make themselves visible in the workplace have been adopted in many hospitals:

“We have a number of staff, mostly Health Care Support Workers, who are able to speak Welsh and we do have a number of patients whose preferred language is Welsh. Those of us who speak Welsh have the Welsh Language Board Logo embroidered on our uniform so that patients are able to identify us easily.” (Staff)

Some Welsh speaking staff may take the view that they lack confidence when conversing in Welsh – yet their knowledge may be sufficient to provide basic care through the language. The challenge

for ward managers and staff will be recognising the point where the nature or complexity of the information makes it imperative that a staff member with a high level of competency in Welsh conveys the information.

■ Users of languages other than English and Welsh

The majority of the hospitals visited felt that they catered for the cultural, spiritual and language needs of minority ethnic patients.

Some of the staff told us that they did not have many patients from minority ethnic groups and did not feel the need to develop in-house systems to address issues around culture and language needs. Instead, they worked flexibly with the resources they had:

“We also have a list of interpreters that we can call on if we have patients whose preferred language is not Welsh or English.” (Staff)

“My first language is Arabic and I understand the need to ensure that we try to respect a person’s preferred language. We have staff here who can speak Welsh and I had a recent case where I asked a colleague who was Chinese to come along to help me with my discussion with a patient who spoke Chinese; we are alert to such matters.” (Staff)

“We had a recent example of a Chinese lady who spoke no English. We were able to get help from one of our colleagues but we also put together a file of photographs of various things to help us communicate when our colleague wasn’t present. It worked well.” (Staff)

“...Staff have learnt Polish phrases” (Staff)

In some discussions with staff there seemed to be uncertainty regarding awareness of, and possible responses to, individual language needs among patients. There was also a concern that staff rely heavily on the family if language and cultural needs are required:

“Have free translation service available, some families prefer to be engaged in the process.” (Staff)

“We do have an individual at the moment who is Italian but we manage and are helped by members of his family.” (Staff)

Inquiry Panel's Findings

Our evidence showed the majority of staff are aware of the translation services available to older people, but it is not a service that is used regularly.

■ Sensory and speech impairment

Concerns were expressed by organisations and individuals about the lack of acknowledgement of sensory and speech impairment, and the provision of adjustments for older people with sight, speech or hearing loss.

We received several accounts detailing inappropriate responses by staff who sometimes failed to take account of sensory or speech loss as part of the wider picture of a person's health and wellbeing.

In one instance, the family of an older woman with both hearing and sight loss had raised concerns about the failure to address her sensory impairments only to be told that "This is an acute ward," implying that her sensory loss had no bearing on her stay in hospital.

This touches on a common experience for those with sensory impairments when in hospital for treating conditions other than their impairment(s):

"Would like them to talk more to me about my care. I have sight difficulties but no one is addressing this. Will have to see optician when I am discharged." (Patient)

"She was obviously confused, deaf... The nurse who was attempting to feed her was shouting at her. When I asked a fellow patient if she (the nurse) was always like this, she indicated that she was..." (Patient)

Some family members felt that no-one sought, or acted on, their advice about how to communicate with patients with speech or hearing difficulties, leaving their relatives feeling socially isolated:

"She had trouble communicating due to previous strokes. This was never taken into account nor enquired about." (Relative)

"Staff did not use the hearing box we took in which assisted mum in hearing and not feeling isolated." (Relative)



Many of these issues were reinforced by the evidence we received from RNID Cymru, and from RNIB Cymru who are both now working with Healthcare Inspectorate Wales to involve people with sensory loss in their programme of unannounced hospital visits. This is a welcome development as our evidence supports the view that more needs to be done to meet the needs of older people with sensory impairments in our hospitals.

Meeting the needs of people with sensory impairments is in part dependent on having the right aids and equipment and for these to be in good working order. We heard of numerous examples in large hospitals where personal effects, particularly hearing aids and glasses, had been mislaid or broken. We also heard that hearing aids were not being checked, properly fitted, or set to the correct frequency to take advantage of any loop system.

During our visits we found that some staff were unaware of the loop system in the hospital. Concern was also expressed that hearing aid batteries were not replaced, often because wards did not have a supply of appropriate batteries. We were told by a relative of how the loss of their loved one's hearing aid made communication unnecessarily difficult during the last few weeks of their life.

“Some staff were also, at times, shouting at the wrong ear which resulted in frustration for the staff... and other patients.” (Relative)

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“There needs to be ready access to amplifiers, large print documents and communication charts.” (Organisation)

It is important that regular checks are made on people's hearing aids, glasses and other aids to ensure they are providing maximum benefit. This should be inherent in the standards of care given and part of the caring, person centred culture of all hospitals.

5. Assistance with eating and drinking

Both the quality of food and the assistance offered with eating and drinking featured throughout our evidence gathering.

Other organisations, most recently the Wales Audit Office, are focusing their attention on all aspects of hospital catering, including food quality and preparation; therefore we do not cover these issues in detail here. In the context of our findings, it is the level of assistance with eating and drinking which most impacts on older people's dignity and respect.

The nutritional quality of food is irrelevant if people cannot physically eat it, and providing appropriate and timely assistance with eating and drinking was an issue of concern raised by a significant number of people.

We heard evidence of food remaining uneaten on trays with no assistance on offer, or of patients struggling to feed themselves being helped by other people's visitors. One organisation told us that uneaten food is sometimes documented as a refusal to eat, despite the need for assistance not having been met. A carer who expressed concern about the level of help on the ward was told that staff lacked time to provide assistance with eating for all those that need it.

“There was no account taken that he was unable to see, had severe trembling of hands, and as a result, was unable to pick up the container of water to drink if he had wanted to... I then spoke to a Staff nurse about this and other issues, and she informed me that she was too busy to do such tasks as she had 28 other patients to look after.” (Relative)

“One patient had advanced Parkinson's disease and it was impossible for her to feed herself and it was distressing to watch her attempts to do so; visitors to other patients had to help her.” (Relative)

We were told of an instance in which an older person had to wait at least four days for a decision to provide liquidised food to be actioned. Another family told us that insufficient support with eating had led to their relative being put on a feed peg - as a consequence the individual has been unable to feed himself orally following discharge. This is not acceptable.

The Welsh Assembly Government now requires hospitals to implement protected mealtimes and we saw that this has brought some positive results. It was generally viewed by staff as a good development, allowing patients to eat without interruption and giving them the best chance of getting the nutrition they need. Staff felt protected mealtimes provided a quiet and relaxed atmosphere in which patients are afforded time to enjoy meals, emphasising the importance of mealtimes as part of the people's care.

“Protected meal time introduction has been welcomed and should improve how we meet the nutritional needs of patients. We help patients to make a good choice from the menus.” (Staff)

However, it was worrying that some relatives and carers told us that they had been prevented from providing assistance with eating to an older person because of the protected mealtimes policy. They expressed concern that staff simply did not have the time to ensure the right sort of support was being given, and yet their willingness to help was being rejected.

“My 82 year old mother went in every day for four weeks to feed him his lunch as he couldn't do it himself. However, when he was moved into another ward, she was stopped from doing so.” (Relative)

“It is stated at the entrance to the ward that visiting is not allowed during mealtimes to allow staff to assist patients to eat... (the older person) told me that she was never assisted even when she requested this, despite her weakness and the insistence of staff that she should eat.”
(Relative)

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“No staff attended the four bed ward during meal times to offer assistance... When we pressed for assistance to be given at meal times (when family were not allowed to visit which was the wider ward policy), Mum told us ‘she rushed and just stuffed the food in my mouth without letting me finish a mouthful’.” (Relative)

We heard a variety of opinions of the use of the Red Tray system, which is designed to identify those patients needing assistance at mealtimes by placing their food on a red tray. One organisation told us that the use of red trays was not consistent. Some staff found the system helpful, others felt it could be stigmatising and used other methods, such as discreet signs near beds, to identify those who need assistance.

To try and address people’s needs at mealtimes, one ward we visited had re-designated a Health Care Assistant post to a Housekeeper role, focusing predominately on meeting the needs of patients at mealtimes. The Housekeeper works during lunch time and evening meals, and takes the practical steps which help mealtimes run smoothly - checking menus, clearing bed tables and making patients comfortable and ready to eat before the meals arrive on the ward.

This role gives increased opportunity to interact with patients and their visitors and has been widely welcomed. It has significantly reduced the time taken to serve meals, helping to create an improved environment during mealtimes, and ensures the regular monitoring of patients’ nutritional intake. Additional funding is now being sought to roll out the system to other wards.

Giving appropriate assistance with eating and drinking is vital to patient recovery, and failure to do so is unacceptable. Part of the way forward must lie in strengthened ward leadership, and through listening to the experiences of older people, and their relatives and carers.

■ Boredom and inactivity

While some Health Boards reported their attempts to address patient inactivity on the wards, one of the most consistent messages we heard, and the regular observation we made during our hospital visits, was that the time spent being treated in hospital equates to a time of boredom and inactivity for the individual.

There is a distinction to be made between therapeutic activity and social activity. Both should be seen as playing a part in supporting a person's rehabilitation and recuperation, and potentially reducing the length of their hospital stay. The aim is to obtain a better balance between rest and boredom.

While recognising the need for a period of post operative or post illness care where rest is an important part of the recovery process, for most people the days spent in hospitals are long. There is often a great deal of activity for staff but patients have little in the way of stimulating social activities to help them through the day. Day rooms too often lack the necessary appeal and staff do not have the time to sit and engage in activities.

Even where the day rooms were bright and cheerful we observed that patients in general seemed reluctant to leave the familiarity and 'safety' of the area immediately around their bed.

On our visits we saw some patients who appeared withdrawn and inwardly focused. More commonly, older people expressed a degree of frustration and resignation that they experience long periods with little to entertain or occupy their minds. It is an impression supported by the words of the older people themselves:

"I find the day very long and boring with no company being in a single room. No one uses the day sitting room."
(Patient)

"The days are long and it does get a bit boring. I've now got the bed by the window and I've got a good view of the town and the hills behind. But it is boring; if they had a computer on the ward that you could go on, that would help to pass the time." (Patient)

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The absence of social activity and meaningful engagement was one of the most powerful impressions we were left with following our visits. Of the hospital staff we interviewed, none talked about having the capacity to encourage patients in activities, exercises and games which are seen to be mentally stimulating. We also noted a lack of appropriate activity for people with dementia, leading to disturbed behaviour and containment strategies by staff.

Some staff members highlighted the need for such activities on the wards, with cards or dominoes being a few of the suggestions. Activities like these can be seen as adding value to a person's rehabilitation and recuperation. However, most of the older people we spoke to were left to entertain themselves.

"I would like to have a range of games or something to do."
(Patient)

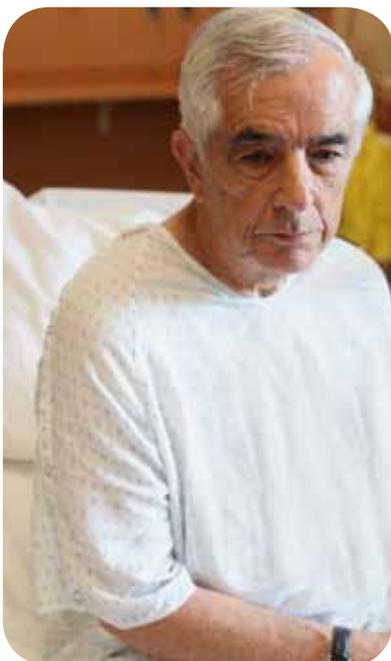
"We don't get newspapers and magazines brought to the ward for some reason; I don't know why." (Patient)

"I am able to go for walks unaided. This helps reduce the boredom as there is little to do except watch TV." (Patient)

These concerns echo some of the key findings of the British Medical Association report 'The psychological and social needs of patients' (BMA January 2011) which called for patients to have the option of engaging in recreational and creative therapies and for the provision

to be reviewed and amended according to the patient and staff mix. Arts and humanities programmes have been shown to have a positive effect on inpatients.

The measured improvements include contributing to positive physiological and psychological changes in clinical outcomes, reducing drug consumption, shortening length of hospital stay, promoting better doctor-patient relationships, and improving mental healthcare. The report cited an earlier study undertaken for the Healthcare Commission in England that linked boredom levels with the relative levels of safety on wards.



In many wards the only activity available was watching television sometimes at considerable cost or listening to the radio. A loud television in a bay is not an adequate substitute for human engagement and interaction. However, one patient remarked that she had been in hospital for three months and she had no access to television or radio. Boredom and inactivity was not a major theme in the written evidence; however, there were a few references made to patients sitting all day with little stimulation:

“A lot of the patients I have talked to find the environment depressing as there is not much stimulation and the set-up may be a bit austere and intimidating.” (Relative)

Several examples were given of the location and use of televisions causing distress to some patients by either being inaccessible, too loud, or being on for extended periods preventing rest:

“All the patients on the ward had poor eye sight and were hard of hearing and yet there was a telly blaring all the time which was out of reach so that no one could switch channel or turn it off.” (Relative)

We suggest that if technology were used more effectively, for example the use of individual headphones, then the problems of intrusive noise could be reduced, at a relatively low cost. It was apparent from our interviews with staff that many are frustrated that they do not have as much time as they would like to talk to the patients. This situation is quite common within most of the hospitals that we visited, limiting what can be done for patients and the sort of activities that can be provided:

“Would like to do more things with the patients, long stay patients need more interaction - some people don't get visitors, only staff interaction.” (Staff)

However, there was some evidence that positive steps are being taken on some wards through the use of volunteers and hospital staff:

“We have now got TVs in each of the bays and Healthcare Support Workers are currently working on developing activities for patients. A patients' survey identified boredom as an issue that we needed to address.” (Staff)

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Some hospitals use volunteers to assist patients by providing company, encouragement and running errands, as well as supporting staff. Examples of good practice we were told of included the well regarded volunteer schemes (See Appendix 9).

The older people we spoke to were very complimentary about their interactions with volunteers and how the volunteers were able to spend time with them. These schemes have worked well, successfully involving a range of volunteers who have been well accepted as part of the multi-disciplinary team.

Every Health Board and the Trust should be making much more imaginative use of volunteers. The ward manager should see and treat them as part of the team. Volunteers can provide good social support, but the boundary with what constitutes the rehabilitation and treatment plan should remain clear. There should be clarity of role, recruitment and training, to optimise the benefits and reduce any inappropriate use of volunteers.

There is great potential for imaginative use of volunteers to support and engage with older patients. Such initiatives should be further developed and encouraged.

6. Dementia care

A significant proportion of older people admitted to hospital will have problems of dementia and confusion; the care they receive should therefore be proportionate to their needs. In this sense it is important to recognise that people with dementia are not a special group, but a key section of people receiving hospital care.

The focus on dementia given through the development of the National Dementia Action Plan for Wales is welcome. There are also useful lessons to be learned from the Alzheimer's Society report **'Counting the Cost, caring for people with dementia on hospital wards.'**⁶

Individual responses focused on poor communication with people with dementia, lack of training for staff, the impact of people with dementia on other people on wards and lack of stimulation. There was evidence given of staff assumptions regarding the capabilities

NOTE:

6. Alzheimer's Society (2009) 'Counting the Cost, caring for people with dementia on hospital wards.'

of a person with dementia leading to unnecessary or inappropriate interventions. Concerns were also expressed about nutrition, personal care and hygiene.

Communication with the relatives of people with dementia was highlighted in a number of accounts. There was particular reference to the scale of the impact of poor communication and the hospital environment on people with dementia. One account speaks of a patient who was:

“Subjected to a catalogue of treatments that induced abject terror in her... a system that does not appear to be able to deal with people who are old, have Alzheimer’s and are taken to hospital.” (Relative)

Another speaks of a person whose cognitive skills were judged by staff to be too limited to allow her to walk again, being moved with a hoist as a result:

“...However, to subject someone to using a hoist for every transfer for the rest of their lives because the cognitive skills are not 100% is appalling.” (Relative)

Suggestions made to us for improvement included having a ward dedicated to recuperating dementia patients and having a person with them as much as possible to talk or reassure the patient or hold their hand.

Vulnerable patients were seen by hospital staff to pose particular challenges. Doctors, nurses and therapists told us that a key issue is to improve the care for very frail and vulnerable older people who have both cognitive and physical fragility. They believe that more investment is needed in the service. Links with psychiatry need to be improved, as currently they are not good enough and not well integrated.

Meeting the needs of confused patients and maintaining standards are seen as challenging and this is perceived as an area that is inadequately staffed; yet there are increasing numbers of patients with



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intense needs in acute care. Staff felt there is a need to improve cross boundary working particularly with mental health services and in arranging care home placements locally for people with dementia.

In one hospital we were told that cognitively impaired patients who are admitted get distributed “all over the hospital” and do not get a cognitive assessment in the emergency department. Improved emergency department assessment could ensure confused patients are moved to dedicated geriatrician led wards for specialised assessment.

We received evidence from organisations regarding difficulties arising between patients who have dementia and those who do not. More specifically evidence pointed towards situations in which patients on hospital wards felt harassed and bothered by patients with dementia. Some patients without dementia can endure challenging behaviour which impacts on their privacy. We were told that some patients can be demeaning about those who have dementia, who were often the ‘unpopular patients’ perceived to be in the wrong place, or at worst a nuisance. Often there was a lack of knowledge in relation to the needs of people with dementia in both acute and community hospitals, a lack of appropriate facilities and environments, and a lack of access to the specialist skilled staff to meet their needs fully.

There was little good practice brought to our attention through the evidence we received. We are aware however that there are examples to be learned from and these are important in terms of demonstrating what is possible.

The provision of basic care for people with dementia was often a source of pride for staff. In a number of areas, nurses expressed high satisfaction with their care for bed bound or very frail people with dementia – helping them with hygiene, comfort and food and drink. Conversely, however, the more agitated patients were seen as a problem. Two key areas of focus in dementia care for the future should be:

- the built environment;
- developing the workforce.

Admission to hospital can be a frightening and disorientating experience for people with dementia, leading to disturbed behaviour and increased risk of falls, increased use of sedation and negative patient experience.

There is a changing trend in hospitals towards more people with dementia being admitted, therefore it is vital that service planning takes account of this.

Most hospital environments were not designed with the needs of people with dementia in mind. This doesn't necessarily mean that they are the cause of all disturbed behaviour, but they will be contributing factors if, for example, it is difficult for the person with dementia to identify where the toilet is, or which room is theirs, because all the doors look the same.



Much of the literature on the environment for people with dementia is derived from long-term care, but the principles of 'dementia-friendly' design are relevant to other healthcare environments including hospitals (as demonstrated by the **King's Fund Enhancing the Healing Environment programme**⁷). Good design doesn't need to be expensive but it does need to be factored in.

On a general note, our observations suggest that priorities have been assigned to single sex accommodation and meeting Disability Discrimination Act requirements relating to physical accessibility in new buildings, whilst creating environments of care appropriate for the needs of people with dementia, also included in the Disability Discrimination Act, have yet to receive sufficient attention.

On our visits, we saw examples of 'containment' strategies such as putting chairs across the top of stairs - this is inappropriate and can be avoided in new build or refurbishment programmes.

We understand that much of the NHS estate consists of old buildings - but this also doesn't mean that patients have to accept poor quality facilities as a matter of course.

NOTE:

7. The Kings Fund (2009) **Enhancing the Healing Environment: A Guide for NHS trusts**

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There is a major issue with patients with (co-morbid) dementia and length of stay. We often heard about the great difficulty in accessing alternative provision for care after the hospital stay. Some of the lengths of stay for those awaiting residential or nursing home care for dementia or care packages are very significant and this is bad for all involved: those with dementia, other patients on the wards, staff and families. There are challenges here for the Welsh Assembly Government as well as for the NHS in Wales.

Specialist skilled input needs to be available, not just advice, equipping staff to deal with patients with dementia. The need remains for further work looking at the experience of people with dementia in general hospital settings. Leadership at both ward and board level is key.

7. Discharge planning

In their evidence, all Health Boards reported major progress in improving the discharge process, ranging from beginning the planning on admission, to improved liaison with Social Services and the third sector, and better communication with patients.

Yet one of the recurring challenges faced by the majority of the staff interviewed was the effective discharge of older patients. Discharge arrangements also featured in evidence from Carers Wales as the issue that caused most problems for carers.

We recognise that preventing avoidable hospital admissions is vital for the future and to be very much welcomed. Improved support in a community setting is likely to reduce the numbers of admissions.



However, this is likely to lead to the more frail and ill patients becoming a greater percentage of those accessing hospital beds. Delayed discharges are problematic and can be caused by the lack of timely home care packages which are sometimes difficult to organise, or a lack of appropriate care facilities in the community. This was often a cause of delay in discharge

for older people with dementia. Consequently some older people are unable to move on and are kept in hospital inappropriately. As a result of these extended hospital stays, some older people lose their independence and mobility skills. Discharge needs to be timely and occur at the optimum point to aid the individual's recovery.

For patients, their families and carers, problems with discharge arrangements involve a breakdown of communication and lack of information:

“No one can answer us when we ask when she will come home. My father who is 80 and also disabled is distressed that his wife is languishing in an institution and is more and more anxious as time goes by. Every time we ask we are told ‘she is waiting for a package of care’. Her assessment revealed she required a ‘steady’ however since this assessment she has deteriorated further and therefore this piece of equipment may not be appropriate. To conclude, a woman who should have not been in hospital for longer than four weeks has now been hospitalised for three months or more with no date for her ‘release’.” (Relative)

Some people reported examples of discharge planning which can only be described as chaotic – a relative told us that at a discharge meeting the doctor was found to be talking about arrangements for the wrong patient. Even on the day of discharge, barriers sometimes emerged or the process didn't work for the benefit of the patient:

“Peg feeds are only done on a Monday, and because someone forgot to book the procedure, discharge was delayed by a week.” (Relative)

“(Patient was) Given a laxative and discharged after breakfast. There was no transport... left to sit until 5pm by which time heavily soiled and distressed... bewildered and completely confused.” (Relative)

Many of the older people and some relatives we spoke with felt disengaged from the process of discharge:

“I don't have enough information about my discharge, I don't know what is happening.” (Patient)

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“I do talk to staff, but I am not able to discuss in any detail due to the lack of time staff spend with me” (Patient)

It is also clear that delay is often a symptom of inadequate links with Local Authority social services. There was a suggestion that ‘out of sight - out of mind’ best described this reality for some of these older people who find themselves a long way from their communities:

“...We have regular meetings of the multi-disciplinary team which are attended by all the relevant specialist staff from the hospital and also the social worker from the local area team (from the county in which hospital is situated)... We have no direct contact with (the adjoining county's) Social Services Department which leads to discharge problems and elderly patients are the ones who lose out. We have similar problems in respect of patients from (another adjoining county); we have too many patients who are having to stay in hospital when they are medically fit for discharge, or who have to wait to go to Community Hospitals.” (Staff)

Where effective multi-disciplinary teams are in place, this helps discharge planning and we heard of several initiatives, often involving the third sector, designed to improve discharge processes. We also saw some examples of good practice, such as the ticket home scheme, (further details can be found in Appendix 9.) However, discharge planning has been reported in a very positive light by some patients:

“I've been involved and included in the discharge planning and was even invited to a discharge conference.” (Relative)

Discharge planning can vary between wards and seems to tie in with circumstances prevailing in the ward rather than needs. A lack of knowledge amongst some staff of the hospital discharge service and its function was mentioned, as well a lack of joint working between health professionals and district nurses.

Effective planning for discharge should start on the first day of admission and be discussed, as appropriate, with the patient and relatives. Where we saw discharge working most effectively social services teams had a staff member based at the hospital who was

a full and active member of the multi-disciplinary team. Alternatively, dedicated social work staff were in daily contact providing continuity in their involvement.

As our evidence indicates, significant problems remain with hospital discharge processes in Wales and these have to be tackled with a renewed sense of urgency. One of the challenges will be to ensure that the right support and care facilities are available to meet older people's evolving needs. This has to be achieved through joint working and joint planning by both health and social services.

Health Boards, the Trust and Local Authorities should jointly undertake commissioning in respect of more effective discharge placements for all patients, especially those with dementia, and there needs to be ongoing review of the adequacy of provision. Health Boards, the Trust and Local Authorities should ensure there are integrated ward teams, including social services, to enable early intervention and planning, and an appropriate range of care packages, including for people with dementia.

■ Older people and diversity

The majority of the hospitals felt that they catered for people's cultural, spiritual and language needs.

Many hospitals had access to community support through a Chaplain and we found some good examples where the Chaplains or local religious leaders were involved in raising the awareness of cultural and spiritual needs. However some patients reported having no contact with Chaplains or visits to the hospital chapel:

“Would have liked to go to Sunday Service in hospital chapel, but this was not offered. Feel religion could be considered more highly.” (Patient)

Limited evidence was provided of good practice in meeting the spiritual and dietary requirements of people of particular faiths:

“We have a multi-faith room and our catering team are up to speed on the implications of catering for patients from differing cultural and ethnic backgrounds.” (Staff)

Apart from the notable exception of mixed sex facilities and wards discussed in an earlier section, we received little direct evidence on gender specific issues.

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We had one written example of the impact of a patient's gender and personal preferences on their experience of care resulting from a request one morning for a dressing change:

“My mother requested a female nurse as she had a poor experience with the male nurse on duty and felt uncomfortable with him dressing the sore on her bottom... (I) was told that if my mother had not been so fussy, a male nurse would have done the dressing earlier in the day. My mother then waited until 23.30pm for the dressing to be replaced. This is totally unacceptable.” (Relative)

In response to the limited information about diversity received by the Panel, the Commissioner undertook a separate piece of work to gather further evidence. The findings of this research can be found in Appendix 8.

8. Cross-cutting themes

When considering the evidence we had gathered and the observations we made, it became clear that there are a number of cross-cutting themes underpinning the extent to which dignity and respect is realised in our hospitals. These issues are discussed in this section.

■ Leadership and staffing

The majority of staff we saw were caring and take pride in meeting the Fundamentals of Care for their older patients.

However, the evidence is that some staff feel ill-prepared to

cope with the needs of patients with dementia and other mental health conditions, particularly those who have delirium, agitation or wandering behaviours. In addition to our direct observation in hospitals across Wales, we have been presented with evidence from individuals and organisations regarding how the needs of frail older people, particularly those with dementia, could be better understood and met by hospital healthcare staff.

While the staff on wards made efforts to use strategies to ensure patient safety, these patients are often marginalised socially by other patients and staff who lack insight into their problems, and marginalised functionally within facilities that are not designed to meet their needs. Older people are cared for across most health services and many of them will have dementia, although estimates of prevalence vary according to the nature of the service. For example, recent research into emergency admissions to hospital has found that the prevalence of dementia is 42.4% in patients aged over 70.⁸

Throughout our evidence gathering and observational visits, we have heard that the case mix of patients is already becoming both more acute and more weighted towards frailer, cognitively impaired patients in hospitals (both acute and community). If future admission avoidance strategies are effective, this is a trend which is likely to continue and lead to the more frail and ill patients being admitted, while others are more effectively managed within the community. In order to ensure all staff caring for older people are adequately prepared to meet the challenge it is essential that they have the knowledge, skills and attitudes required, including meeting the needs of older people with dementia and other mental health conditions.

Staff development has to be a priority for the Health Boards and the Trust, and this emphasis would be supported by organisations which gave us evidence such as the Royal College of Nursing, the Alzheimer's Society, and Age Cymru. Delivery of effective staff development is sometimes difficult in practice. Strong clinical leadership is essential for this, including deploying the skills of experts in the care of older people. Yet we observed little evidence of non-medical clinical leaders in the care of older people. With nurses constituting the majority of staff and caring for patients with needs

NOTE:

8. Sampson E L (2009) Dementia in the acute hospital: prospective cohort study of prevalence and mortality *Br J Psychiatry* 195(1): 61-6

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ranging from acute care and rehabilitation to end of life care, they are a key staff group from which to draw the non-medical leadership for older people. The potential benefits of executive nurse leadership are well set out in the **King's Fund publication From Ward to Board**.⁹ This identifies the importance of the nursing contribution in championing a focus on clinical issues and the patient experience and ensuring this receives a high profile within NHS organisations.

We met a number of senior nurses who were positive about this role and in leading their teams through ongoing health service change. Underneath this level, however, ward managers are struggling to meet the challenges of managing and staffing their wards without always having easy access to a supporting structure of clinical specialists who are experts or advanced practitioners in the care of older people. These specialists can provide direction to skills development and implementation of evidence based practice.

We observed that much work on general leadership development has been done, such as implementation of the Free to Lead, Free to Care programme for ward managers. The meaning of Advanced Nursing Practice is also currently being explored and defined in the context of developing nursing staff in Wales. A strategic vision and frameworks have been published in reports such as **Modernising Nursing Careers** and **Designed to Realise Our Potential**.¹⁰

The Welsh Assembly Government commissioned the report Nurture Ability and Develop Future Nurse Leaders¹¹ as part of the Modernising Nursing Careers UK programme. This set out the priority areas "To develop existing and new roles and flexible career pathways for nurses" and recommends that "All Health Departments to consider commissioning succession development programmes for staff aspiring to significant strategic level clinical nursing roles requiring advanced level of practice, for example nurse consultant".

NOTE:

9. The Kings Fund (2009) From Ward to Board: Identifying good practice in the business of caring
10. Welsh Assembly Government (2006) Modernising nursing careers: setting the direction and Welsh Assembly Government (2008) Designed to reach our potential: A 'Beliefs and Actions' Statement for Nurses, Midwives and Specialist Community Public Health Nurses for 2008 and Beyond
11. Welsh Assembly Government (2008) Designed to reach our potential: A 'Beliefs and Actions' Statement for Nurses, Midwives and Specialist Community Public Health Nurses for 2008 and Beyond

These are good beginnings; however, we found limited evidence that this has been taken forward in the context of caring for older people. The Welsh strategy recognises the roles of both advanced and specialist practice and the need for modernisation and succession planning. We would like to see this specifically applied to the challenge of meeting future needs of older people in hospital. This could include exploring the potential for further development of the Health Care Support Workers role as well as career models up to Consultant level.

The **Post Registration Career Framework for Nurses in Wales**¹² was published in 2009, providing a structure for development of professional nursing within which skills development in the care of older people for both general and specialist nurses could sit. To apply this to the context of enhancing staff skills to better meet current and future needs of older people would be a positive step.

There may be a role for the specialist sections of professional organisations to further explore both the current situation and strategies for strengthening the specialist contribution and leadership. Many other organisations can also contribute to this but the role of the Health Boards and the Trust is vital, with support from professional organisations, education providers and the third sector. More has to be done to further progress existing work on staffing levels, developing a robust means for determining the proper level of staffing on every ward.

■ The role of the ward manager

It is our view that although the Health Boards and the Trust have begun to embrace the dignity and respect agenda, there is still much progress to be made before the principles of this agenda are applied consistently in practice throughout NHS Wales.

In their evidence, each Health Board described clear lines of accountability from the Board to the ward for dignity and respect, and most explicitly recognised the importance of the ward manager in this area. The Fundamentals of Care audits are clearly a key part of this process. We received a large number of documents detailing policies at hospital and ward level, dignity charters, and the results

NOTE:

12. Welsh Assembly Government (2008) Modernising nursing careers project report: Nurture ability and develop future nurse leaders

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of audits carried out, for example, Fundamentals of Care. This is a good beginning. However, the written evidence we received together with the conversations we had and our own observations throughout Wales demonstrated that in some instances, dignity and respect is not a reality.

As set out in our findings, we found examples of poor communication, especially pronounced where the patient had some degree of cognitive or sensory loss; we heard about fundamental and essential care which was not always of an acceptable quality, particularly in terms of prompt and supportive responses to toileting and continence needs; and we were told of a minority of cases of brusque, even rude and demeaning attitudes of individual nurses which were particularly distressing to the patient. Such instances, even if relatively low in number, are unacceptable.

A frequent point made by both patients and staff was that these deficiencies were thought to be the result of under staffing, particularly of busy acute wards. Nevertheless we also found that in several hospitals, even in very busy acute wards, the quality of care in all of these aspects was excellent. It is our observation that the common factor that produced such excellent care was the leadership demonstrated by the ward manager. These were committed, compassionate, skilled, knowledgeable and determined staff who had a passion for providing patient centred care for those in their charge and inspiring in their staff the same passion. They were achieving this despite having to overcome the same barriers to good care as others, often in the same hospital.

The importance of clinical leadership, and the needs which ward managers may have in terms of the complex problem of caring for patients with dementia in an acute setting, are described in the section of the report on dementia care. However, equally important is the degree of authority given to the ward manager by the hospital to allow them to put into place the necessary staff and other resources to produce excellent and appropriate care.

Some ward managers told us that despite the considerable investment in initiatives such as developing clinical leadership programmes and “Empowering Ward Sisters”, they were not allowed to select the staff for the ward themselves. Therefore, they had no opportunity to assess the skills, knowledge, and, most importantly,

the attitudes of the staff for the complex and demanding task of caring for frail older patients.

We were concerned to learn that many ward managers were not aware of the recommended staff complement for a ward offering services of the kind we visited, and that clinical supervision and regular appraisal of nursing staff is honoured more in the breach than the observance in many parts of NHS Wales. Thus, the training needs of staff are not assessed and even where these are obvious, the ability to release them from ward duties for training is apparently very limited due to pressure of work.



We also learned that restrictions on the pattern of working hours of senior nurses could result in the ward having no senior nursing cover “out of hours” and at weekends. Both these are times when medical staff are less available so experienced senior nursing staff are more needed. It is also a time when a patient’s relatives may wish to speak to someone in authority about the patient’s progress.

As a Panel we are of the view that effective ward leadership is essential to an approach based on common values including respect for dignity and the position of the ward manager is pivotal to the achievement of patient centred care. This needs to be supported by the Boards, the Trust, and senior staff who should have regular and reliable data on whether their patients’ dignity and respect are being preserved, and whether these crucial aspects of care are getting better or worse. It is imperative that each ward should have a ward manager selected for their clinical leadership ability, who has full information on the appropriate staff complement for the type of care being provided on that ward.

They should be fully involved in the selection of the nursing and health care assistant staff on the ward and have responsibility for the appraisal of nurses and ensure that their training needs are regularly assessed and met. The ward manager should be empowered to decide their own pattern of work and that of other colleagues, and to involve volunteers appropriately on their wards. They should have ready access to specialist nursing colleagues as necessary and as described in the section on dementia care (page 58).

Inquiry Panel's Findings

■ The patient experience

Health Boards and the Trust need to be able to assure themselves that the reality of people's experience in their hospitals matches the ideals set out in their policies and procedures, and in national standards and frameworks.

While they can offer vital insights, relying on issues brought up through complaints is not enough. Systematically measuring patient experience and sharing and adopting good practice is part of the answer to how improvements can be achieved. All Boards are using patient stories as a way of raising awareness of dignity and respect issues from Board level to wards, but more is needed.



The Welsh Assembly Government needs to develop a simple framework, for use by all Health Boards and Trusts, whereby patient's experiences can be captured and analysed to ensure they meet their responsibilities around patient dignity and respect.

There is also the need to more clearly identify a mechanism, or an organisation, to be tasked with disseminating good practice, and ensuring it is consistently implemented on an all Wales basis. We recognise that disseminating good practice is only part of the answer, and that more needs to be done to evaluate what should be accepted as good practice. When this has been clarified, the Health Boards and the Trust should be prepared to adopt such practice or to justify why they are not doing so.

The use of volunteers is one example of an area that should be informed by good practice but adapted to circumstances. We saw volunteer schemes working well in wards in Wales, and making a real difference to older people's experience.

The ward manager should be influencing and directing the use of volunteers to support and engage with older patients. Volunteers can provide good social support but the boundary with what constitutes the rehabilitation or treatment plan should remain clear. There should be clarity of role, recruitment and training, to optimise the benefits and reduce any inappropriate use of volunteers.

The use of volunteers to support and engage with older patients should be further developed and imaginative initiatives should be

encouraged whilst striking a balance in relation to not compromising clinical care.

Innovative use of volunteers is one example of good practice that needs wider recognition, but there are many others. We know that work has, and continues to be done to share good practice across many areas of public service, but we did not see enough evidence of it being embraced and adopted as it should be. We see an important role for the Welsh Assembly Government, Health Boards and the Trust in continually striving to identify and implement good practice for the benefit of staff and patients.

■ Attitudes, knowledge and skills

Very few older people, their families or carers told us they were concerned about staff lacking knowledge or skills.

There were some references to poor language competency, but far more common were concerns about the availability of staff and their attitudes towards older people and care. From our interviews with staff there was a clear commitment to maintaining and developing knowledge and skills reflecting the NHS structure of staff appraisal and development of the Knowledge and Skills Framework (KSF). There were very few accounts of approaches aimed specifically at developing positive attitudes towards older people.

Attitudes are formed and maintained by many influences. Some, such as family and cultural background, are outside the workplace. Others such as training, leadership and work experience are firmly within. Change can be supported through training and good role modelling which brings about the manifestation of positive attitudes and modified behaviours.

The Health Boards and the Trust need to ensure that through recruitment, staff selection, and development they attend to attitudes as well as knowledge and skills. Systematic failure to address this can lead to the recruitment of unsuitable individuals.

Conclusion

We recognise the work that is already underway in the health service in Wales in bringing about improvements in care. We found evidence that positive progress is being made, but it has not gone far enough. Even in difficult economic times, change can be achieved if the will exists, and it is vital now that the

Inquiry Panel's Findings

ground already gained is not lost and that the momentum for change gathers pace.

In general a wider understanding of the ageing process and its implications for clinical practice is needed. We also need to distinguish between pre-existing needs and hospital induced needs. There should be better recognition of the connection between issues which arise as a result of a hospital stay, such as delayed discharge and avoidable incontinence, and the eventual outcomes for the future independence of individual patients.

The health service should be better able to meet the often complex needs of frail older people within a hospital setting. The features of frailty often include sensory impairments and good communication is central to effective care. Appropriate support and advocacy needs to be available for older people so that they remain informed and are able to express their views about their care. Every member of staff on the hospital ward needs knowledge of how to work with older people and people with dementia.

We were concerned, for example, that while the most common mental health problem in older people is depression, we received little evidence of awareness of the need for early recognition and diagnosis. We also have concerns about end of life care. It is important that staff are well trained, recognise when they are providing end of life care, and behave appropriately.

The health service in Wales needs to seize the opportunity to transform healthcare making it much more responsive to the needs of older people. If focus and imagination are applied then real improvements are possible.

The Panel has brought issues to the attention of the Older People's Commissioner for her to consider when framing her recommendations. We believe these will help to drive improvement in practice. Some are cross cutting and are designed to allow the exercise of local judgement in achieving dignified care for older people.

We all need to understand how important this agenda is and how it will benefit not only older people who use hospitals but also those who work in them. Improvements must happen now. This is also the agenda of the future.

The way forward

The publication of this report including its recommendations is only the beginning. Everyone who has given generously of their time to assist with this Review rightly anticipate that the recommendations will lead to concerted action.

■ Implementation of the recommendations

Using the Commissioner's legal powers¹³ we have requested that the organisations subject to recommendations in this report provide in writing by 14 June 2011, an account of:

- how they have complied, or propose to comply, with the recommendations; or
- why they have not complied with the recommendations; or
- why they do not intend to comply with a recommendation/s.

Formal written notices will be issued to any organisations which fail to respond or which provide inadequate information. If after this process the response received is not deemed satisfactory, the Commissioner reserves the right to draw it to the attention of the general public.

■ Recommendations register

The Commissioner is obliged to keep a register of the recommendations made in the report and the actions taken in response. The register must be available for the general public to view. It will be published on the Commission's website, and made available to individuals on request.

■ Working in partnership

Wherever possible we will work with other organisations to monitor the implementation of our recommendations.

Much of what we have learnt during the course of the last twelve months will apply equally to other care settings and we will endeavour to spread our knowledge more widely.

NOTE:

13. Commissioner for Older People in Wales Regulations 2007, Reg. 15 (2007/398)

Thanks and acknowledgments

We would like to express our thanks to all those who have been involved in our first Review. We would especially like to acknowledge:

- Older people and their families, carers and fellow patients who have provided written evidence and those who took part in the hospital visits.
- The individuals, groups and organisations that provided written evidence.
- Hospital staff who spoke with us and helped organise our visits.
- The organisations and individuals who provided support and advice particularly: A Dignified Revolution, Age Cymru, Alzheimer's Society, Board of Community Health Councils in Wales, British Geriatrics Society Wales, Equality and Human Rights Commission Wales, Healthcare Inspectorate Wales, Health Solutions Wales, Dr Jocelyn Cornwell, National Leadership and Innovation Agency for Healthcare, Professor Sir Mansel Aylward, Royal National Institute for Deaf People Cymru, Royal National Institute of Blind People Cymru, Royal College of Nursing Wales, Dr Alison Parken, Dame Elizabeth Fradd, Rob Powell, Professor Bob Woods, Dr Win Tadd and the Wales Audit Office.
- The seven Health Boards and Velindre NHS Trust for providing written evidence and supporting the Call for Evidence and announced hospital visits.
- Professor Marcus Longley and Catherine Wilson of the Welsh Institute for Health and Social Care, University of Glamorgan.

And finally we would like to extend sincere and special thanks to the Panel of Inquiry chaired by Dame Deirdre Hine for sharing their expertise and for their dedication to the Review.

Appendices



Appendix 1: United Nations (UN) Principles for Older Persons¹⁴

The UN encourages Governments to incorporate the following principles into their national programmes whenever possible:

■ Independence:

1. Older persons should have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help.
2. Older persons should have the opportunity to work or to have access to other income-generating opportunities.
3. Older persons should be able to participate in determining when and at what pace withdrawal from the labour force takes place.
4. Older persons should have access to appropriate educational and training programmes.
5. Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.
6. Older persons should be able to reside at home for as long as possible.

■ Participation:

7. Older persons should remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations.
8. Older persons should be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities.
9. Older persons should be able to form movements or associations of older persons.

NOTE:

14. United Nations (2002) Report of the Second World Assembly on Ageing
http://www.un.org/ageing/un_principles.html

■ Care:

10. Older persons should benefit from family and community care and protection in accordance with each society's system of cultural values.
11. Older persons should have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.
12. Older persons should have access to social and legal services to enhance their autonomy, protection and care.
13. Older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.
14. Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives.

■ Self-fulfilment:

15. Older persons should be able to pursue opportunities for the full development of their potential.
16. Older persons should have access to the educational, cultural, spiritual and recreational resources of society.

■ Dignity:

17. Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse.
18. Older persons should be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution.

Appendix 2: Dignity and respect – the emerging agenda

Dignity is everybody's business, from older people to those charged with their care. Care providers, policy makers and regulators must ensure that the care received by older people in hospital is centred on the individual and maintains their dignity at all times.

The last decade has seen a growing awareness of the threats to older people's dignity and respect posed by many aspects of routine hospital care.

■ Studies encompassing dignity and older people

There have been a range of studies highlighting concerns about the dignity of hospital inpatients. Four major reviews of the evidence on ageism and age discrimination in various settings in health and social care have been conducted for the **Centre for Policy on Ageing**.^{15,16,17,18}

There have also been formal inquiries into dignity and related issues. The **Joint Parliamentary Committee on Human Rights** said that during the course of their inquiry, they received a considerable volume of evidence about the quality of treatment that older people receive in hospitals and residential care homes.¹⁹ They heard examples of both good and bad practice, and although there were far more examples of good practice, many witnesses, including

NOTES:

15. Clark A, Hayes R, Jones K and Lievesley N (2009) Ageism and age discrimination in primary and community health care in the United Kingdom: a review from the literature, Centre for Policy on Ageing
16. Lievesley N, Hayes R, Jones K and Clark A (2009) Ageism and age discrimination in secondary health care in the United Kingdom: a review from the literature, Centre for Policy on Ageing
17. Clark A, Hayes R, Jones K and Lievesley N (2009) Ageism and age discrimination in social care in the United Kingdom: a review from the literature, Centre for Policy on Ageing
18. Lievesley N, Hayes R, Jones K and Clark A (2009) Ageism and age discrimination in mental health care in the United Kingdom: a review from the literature, Centre for Policy on Ageing
19. House of Lords House of Commons Joint Committee on Human Rights (2007) The Human Rights of Older People in Healthcare: Eighteenth Report of Session 2006-07 London: Stationery Office

the Inspectorates, providers and organisations supporting older people, expressed concern about continuing poor treatment of older people in healthcare. Their principal concerns related to:

- Malnutrition and dehydration
- Abuse and rough treatment
- Lack of privacy in mixed sex wards
- Lack of dignity especially for personal care needs
- Insufficient attention paid to confidentiality
- Neglect, carelessness and poor hygiene
- Inappropriate medication and use of physical restraint
- Inadequate assessment of a person's needs
- Too hasty discharge from hospital
- Bullying, patronising, and infantilising attitudes towards older people
- Discriminatory treatment of patients and care home residents on grounds of age, disability and race
- Communication difficulties, particularly for people with dementia or people who cannot speak English
- Fear among older people of making complaints
- Eviction from care homes

In their report, **Caring for Dignity - A national report on dignity in care for older people while in hospital**,²⁰ the Commission for Healthcare Audit and Inspection reported a number of key themes as the essential elements for ensuring that older people's personal needs were being met in a way that respected their dignity. These were:

- Involving older people in their care
- Delivering personal care in a way that ensures dignity for the patient
- Meeting core standards
- Having a workforce that is equipped to deliver good quality care
- Strong leadership at all levels
- Supportive ward environment

NOTES:

20. Commission for Healthcare Audit and Inspection (2007) *Caring for Dignity - A national report on dignity in care for older people while in hospital* London: CHAI

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Overall, the Commission for Healthcare Audit and Inspection was encouraged by evidence that acute trusts were making efforts to respond to concerns about delivering care that respects dignity. The practices they saw in many trusts demonstrate that, despite shortages of staff, it is possible to achieve the levels of service that patients and their families rightly expect.

However, it was felt that there was still a considerable need for improvement in many areas, including need for more skilled staff, better training and awareness for dealing with patients with certain conditions, providing role models, good leadership and better planning of resources.

In making their recommendations the Commission for Healthcare Audit and Inspection pointed out that dignity is a human rights issue and should be the underlying principle for delivery of services. The Equality and Human Rights Commission's Human Rights Inquiry also recommends human rights be mainstreamed and afforded greater visibility, and that human rights are incorporated into the leadership roles within public services.

The Patients Association recently published '**Patients not Numbers, People not Statistics**'²¹ which captured sixteen first-hand accounts of patient care in hospital. Their aim was to highlight the unacceptable experiences facing patients in the United Kingdom on a regular basis. They called on the UK Government and the Care Quality Commission (in England) to conduct an urgent review of the standards of basic care being received by patients in hospital and demanded stricter supervision and regulation of hospital care.

NOTES:

21. Patients' Association (2009) Patients not Numbers, People not Statistics
accessible from <http://www.patients-association.com/Research-Publications/297>

Appendices

In a study for the English Department of Health, senior managers from the NHS and local government examined the extent of age discrimination in health and social care services. Their conclusions²² reveal that despite recent progress, and the good service received by many people of all ages, age discrimination remains an issue for the health and social care system which all organisations need to address.

They argue that a specific focus on age at a local level is required: local audit and planning processes should include an age dimension, and clear action to advance age equality and tackle discrimination needs to be identified and followed up locally.

Sir Michael Parkinson in his personal account²³ of his year as the 'Dignity Ambassador' (part of the UK Government's Dignity in Care campaign), calls for an end to stereotypes of older people, and for health and care staff to take small, cost-free steps to ensure that patients and residents are treated with dignity. This includes not calling them by inappropriate and unwelcome pet names, maintaining their appearance and ensuring that they had their own clothes. The high volume of letters he received told him such lapses were not uncommon.

He also criticised the "sometimes casual, vague and unfeeling responses" the organisations concerned gave to those who made a complaint. He describes this as the language of delay, the sense of a complaint sinking without trace in a bureaucratic quagmire, the suspicion of a cover-up that really upsets people.

He said that staff and managers blamed bureaucracy for stopping them delivering more dignified care, saying common sense seemed to be missing in the way targets were implemented.

NOTES:

22. Carruthers I and Ormondroyd J (2009) Achieving age equality in health and social care: a report to the Secretary of State for Health

23. Parkinson M (2010) My Year as National Dignity Ambassador

Appendices

■ Complaints relating to dignity and respect

There should not be a reliance on complaints as the main means to understand the patient experience, but they can offer some useful insights.

The Welsh Assembly Government collects statistical data on NHS complaints and publishes annual reports, but these do not give a breakdown of complaints by age or other demographic factors.²⁴ Community Health Council complaints advocacy services reports do provide a breakdown by age. The 2008/09 report identified that half of all complaints come from people aged over sixty.

The service area that received most complaints was medicine (33%) and within medicine, the highest number of individual incidents concerned the care of older people (20%). The main subject of all complaints was treatment in clinical practice (47%), however, communication (14%) was also a significant area of concern. Attitudes and information given to patients or next of kin were the most complained about issues related to communication.²⁵

A qualitative study entitled 'Dignity as a feature of complaints made by older people'²⁶ identified common themes in complaints including person centred care, upholding human rights, promoting autonomy, and the perceived ageism and patronising attitudes displayed by some staff.

This study also found that the majority of complaints examined were made by advocates, and recommended that patients and their carers should be encouraged to seek help from advocacy services.

NOTES:

24. Lambert S (July 2010) A scoping study of complaints procedures in Wales for the Older People's Commissioner for Wales

25. Board of Community Health Councils in Wales, Complaints advocacy service report for Community Health Councils, 2008-2009.

26. Dolben E A (2010) Dignity as a feature of complaints made by older people

■ Major developments in Wales and their relevance to dignity and respect

The overarching strategic direction for health services in Wales is most recently set out in 'Designed for Life' which aims to create a world class health service in Wales by 2015 including the overarching aim of ensuring services are provided as close as possible to the patient.

Dedicated strategies and action plans have also been developed for particular medical conditions. Local interpretation of policy priorities are delivered through statutory Health, Social Care and Well-being strategies.

The **Health Standards for Wales**²⁷ set out the Assembly Government's common framework of standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings. They aim to provide a consistent framework that enables health services to look across the range of their services in an integrated way to ensure that all that they do is of the highest quality and that they are "doing the right thing, at the right time, for the right patient in the right place and with the right staff". The latest standards came into force in April 2010. NHS organisations are required to carry out self-assessments annually on the standards and make a public declaration outlining performance. Healthcare Inspectorate Wales has a key role in testing performance against these standards with a particular focus on patient experiences.

An important initiative to establish and then monitor the delivery of standards is the **Fundamentals of Care** guidance, originally issued in 2003. This sets out priority areas for all services in Wales, including communication; dignity, privacy and informed choice; safety; independence; rest and sleep; personal hygiene; appearance and foot care; eating and drinking; and toilet needs. Boards and Trusts arrange for their services to be audited against these standards, and leaflets are available for patients setting out their entitlements against each standard.

NOTES:

27. Welsh Assembly Government (2010) Doing Well, Doing Better: Standards for Health Services in Wales <http://www.nhswalesgovernance.com/display/Home.aspx?a=130&s=2&m=0&d=0&p=0>

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The **Board Development Programme** currently being delivered to the Local Health Boards and NHS Trusts in Wales by the National Leadership and Innovation Agency for Healthcare (NLIAH) pays particular attention to the areas of due diligence, assurance and risk assessment, and strategic direction.

Recent revelations about poor and unacceptable quality and safety of services such as those exposed in the Mid Staffordshire NHS Foundation Trust, clearly demonstrate that effective governance should be paramount in today's NHS, and that where Boards are not well enough equipped and informed to oversee the management of their organisation and its performance, things can go badly wrong.

A focus on governance at the Board level is being matched by various initiatives designed to stimulate leadership at the ward level. When patients and their families enter hospitals, they should have confidence that they will receive high-quality care designed around their needs. **Transforming Care**²⁸ is a ward based improvement programme closely linked to the successful **1000 Lives** campaign and its successor **1,000 Lives Plus**, that empowers ward teams to improve the quality and efficiency of the services they provide.

Transforming Care brings together the best of two initiatives, Transforming Care At the Bedside and Releasing Time To Care. It has four specific objectives: to increase the amount of time healthcare staff spend in direct/value added patient care to 70%; to reduce locally defined adverse events by 50%; to increase patient satisfaction to at least 95%; and to increase staff satisfaction to at least 95%.

Free to lead, Free to care - Empowering ward sisters/charge nurses ministerial task and finish group Final Report²⁹ identified the centrality of the ward sister/charge nurse in determining and delivering key aspects of the Fundamentals of Care and other core elements of provision. The phrase "The Ward Sister/Charge Nurse should have the authority to decide..." is used frequently in the report.

NOTES:

28. <http://www.wales.nhs.uk/sites3/page.cfm?orgid=781&pid=31388>

29. Welsh Assembly Government (2008) Free to lead, Free to care - Empowering ward sisters/charge nurses ministerial task and finish group Final Report Cardiff: Welsh Assembly Government

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Another initiative designed to increase the ability of staff at all levels - from Board to ward - to focus on the patient's experience is the new interest in **patients' stories**. Many boards' meetings now include a specific slot devoted to such stories, and NLIAH and other agencies have taken a lead in collecting and using such material. Various examples are available on the NLIAH website.³⁰

The **physical environment** of the ward has been a priority for several years. The Hospital Patient Environment (HPE) initiative was developed in response to the requirements set out in **Improving Health in Wales: A Plan for the NHS and its Partners**,³¹ which states that "The people in Wales, and the health professionals who care for them, have the right to expect health care delivered in a modern, clean, well maintained environment".

Community Health Councils were asked to carry out an audit of hospital environments, the findings from which would contribute to a process of continuous improvement in the raising of non-clinical national standards.

The first exercise was carried out in 2003 and focused on all the District General Hospitals in Wales. In 2005, fourteen community hospitals were included in the round of visits. The 2009 round saw a significant change to the process, as unannounced visits superseded the former arrangement whereby Trusts were given five days prior notice of CHCs intention to inspect on certain dates.³²

NOTES:

30. <http://www.caretolead.tv/content/>

31. NHS Cymru Wales (2001) *Improving Health in Wales: A plan for the NHS and its partners* Cardiff: National Assembly for Wales

32. Williams G R (2009) *Hospital Patient Environment - External Assessment Visit: Annual Report*, Board of Community Health Councils in Wales
<http://www.wales.nhs.uk/sites3/page.cfm?orgid=236&pid=6265>

Appendices

■ The role of the third sector in Wales

Launched in 2002, Building Strong Bridges (BSB) is the Welsh Assembly Government's programme for strengthening partnership working between the third sector, social services and the NHS in Wales.³³

It aims to ensure that the skills and expertise of the third sector can be maximised, and that the third sector play their role as a key partner in the process of improving health and well being in Wales.

An evaluation of the impact of the BSB programme in 2008 highlighted examples of effective partnerships and “noted considerable scope for Local Health Boards, NHS Trusts, Local Authorities and other stakeholders to work together to add value to local initiatives and to develop even stronger bridges between the third and other sectors through joint working.”³⁴

Taking forward the recognition of the third sector's role, in November 2008 the Welsh Assembly Government published **Designed to add value**. This strategy sets out the Government's vision of the strategic direction for the third sector in supporting health and social care.³⁵

The strategy is intended as a guide to future direction, focusing effort and resources in those areas where added value for all can best be maximised. Improved hospital discharge and volunteering are identified as key themes and are areas where evidence supports the positive impact of the sector.^{36, 37}

NOTES:

33. <http://wales.gov.uk/topics/health/publications/health/strategies/3361338/?lang=en>

34. Hughes K and Longley M (2005) Building on Strong Foundations: Evaluation of the Building Strong Bridges Health and Social Care Facilitators Posts in Wales. Report for the National Assembly for Wales. WIHSC.

35. <http://wales.gov.uk/topics/health/publications/health/strategies/designedaddvalue/?lang=en>

36. Zinovieff F and Robinson C A (2010) The Role of the Voluntary Sector in Delayed Transfer of Care (DToC)/Hospital Discharge and Prevention of Readmission. Bangor: Bangor University

37. Collis B, Russel V, Roberts, R, and Tann J, (2010) An impact assessment of the Ward Volunteers (Robins) scheme for the North Wales NHS Trust (Central) now Betsi Cadwaladr University Health Board. Rhyl: Wales Council for Voluntary Action

Action on individual issues relevant to dignity and respect

■ Delayed transfers of care

Delayed transfers of care have received considerable attention in recent years, and several major reports,^{38 39} have recommended a range of inter-locking measures to reduce both their prevalence and duration. These range from the need to ensure a sufficient and balanced range of services and accommodation for people of different needs in each locality, to a variety of operational measures designed to ensure the efficient and timely delivery of services for people in hospital.

Critical factors include the need for all agencies and professions to work closely together, and for discharge planning to begin as soon as possible (even before admission, in the case of planned admissions). The progress of local health and social services bodies in reducing such delays is monitored closely.

■ Nutrition

The nutrition of patients in hospital is also receiving attention. The Wales Audit Office is currently undertaking a major update of its review into hospital nutrition in 2001 - a report is anticipated imminently. Age UK's and Age Cymru's **Hungry to be Heard** initiative⁴⁰ is calling for all hospital wards to effectively implement its seven steps to end malnutrition. It calls on governments to introduce compulsory monitoring of malnutrition in hospitals.

NOTES:

38. Longley M J, Beddow T, Bellamy A, Davies M, Griffithsw G, Magill J, Scowcroft A, Wallace and Warner M (2008) Independent Review of Delayed Transfers of Care in Wales Cardiff: Welsh Assembly Government ISBN 978 0 7504 4662 4
39. Wales Audit Office (2009) Delayed Transfers of Care Follow Through Cardiff: Wales Audit Office
40. Age Concern and Age UK (2010) Still Hungry to Be Heard: the scandal of people in later life becoming malnourished in hospital
<http://www.ageuk.org.uk/get-involved/campaign/malnutrition-in-hospital-hungry-to-be-heard/>

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■ Dementia

The Welsh Assembly Government is committed to ensuring that people with dementia and their families receive the appropriate support and help, with respect for their dignity. In October 2008 the Minister for Health and Social Services established a Dementia Task and Finish Expert Group. This brought together health and social care professionals, the third sector and other key stakeholders to identify what was needed to be done in Wales.

Building on the work of this group, in January 2010, the Minister established four stakeholder groups with independent chairs. These groups proposed affordable, practical and realistic actions for delivery in four key priority areas:

Improving service provision through better joint-working across health, social care, the third sector and other agencies; improving early diagnosis and ensuring timely interventions; improving access to information and support for people and ensuring a greater awareness of advocacy services; and improving training for those delivering care.

■ Patient confidentiality

A new website and guidance was launched in 2008 entitled '**Caldicott: Principles into practice**'. This contains forty assessment standards around which maintaining patient confidentiality can be evaluated. The guidance issued in Wales is both separate and lengthier than the England equivalent.⁴¹

■ Social interaction

The importance of social interaction - and the harm potentially caused by boredom - has gained greater recognition recently. Doctors are increasingly aware of the importance of developing good communication skills and of attending to their patients' psychological and social needs as a part of holistic practice. In a recent report,⁴² the British Medical Association noted that creating a therapeutic healthcare environment extends beyond the elimination of boredom.

NOTES:

41. Caldicott F (2008) Caldicott: Principles into Practice (C-PIP) <http://www.wales.nhs.uk/caldicott>

42. BMA Science and Education Committee (2011) The psychological and social needs of patients. BMA: London
http://www.bma.org.uk/health_promotion_ethics/psychologicalandsocialneedsofpatients.jsp?page=7

■ Diversity

The NHS Centre for Equality and Human Rights has undertaken pioneering work in addressing and promoting equality and human rights through training, leadership initiatives, and the establishment of, and support, for champions.

An NHS Welsh Language Unit and Taskforce have been established to explore and address the important area of language preference in service delivery. Annual awards take place to mark notable practice in this policy area.

New standards for spiritual care were introduced by the Minister for Health and Social Services in May 2010 linked to the Standards for Health Services. These are designed to ensure a more consistent approach to equality and the development of an integrated approach to religious and spiritual care.

■ Sensory impairments

Recognising the differing needs of patients in relation to sensory impairment remains a challenge.

At the request of the Minister for Health and Social Services, work is underway in Wales through RNIB Cymru and RNID Cymru to explore the issue of sensory loss and healthcare. The ensuing report **'Accessible Healthcare for People with Sensory Loss in Wales'** is expected to be published in 2011.

■ Gender

Most hospitals in Wales are unable to provide separate facilities in admission units and critical care areas and indeed mixed gender facilities appear more acceptable to patients in these areas.

The Welsh Assembly Government is committed to abolishing mixed-sex ward accommodation and to ensuring the safety, privacy and dignity of patients.

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This commitment is underpinned by a hospital accommodation policy that requires Local Health Boards and NHS Trusts in Wales to ensure that patients are cared for in single-sex accommodation in:

- Single-sex wards with single sex toilet and washing facilities preferably within or adjacent to the ward, or
- Single rooms preferably with en-suite facilities or adjacent single-sex toilet and washing facilities, or
- Single-sex accommodation in a ward (i.e. bays or rooms which accommodate either men or women, but not both) with gender specific bathing and toilet areas preferably within or adjacent to the bay or room.

In addition, in particular for mental health accommodation, access to single-sex facilities should be via a single-sex route, and separate communal areas for men and women should be set aside. This policy, however, does not apply in circumstances where immediate intensive medical care is the overriding priority, such as intensive care units.

In June 2008, the Minister for Health and Social Services also announced that all new hospitals in Wales will be built to ensure the provision of single-sex accommodation.

In November 2009, the Welsh Assembly Government undertook an assessment of the extent to which NHS organisations in Wales were complying with the hospital accommodation policy. The initial results indicated that good progress is being made with regard to the provision of single-sex ward/sleeping accommodation.

However, the results also indicated that further work needs to be undertaken with regard to the provision of single-sex toilets / washing and bathing facilities and the requirement to provide separate communal areas for men and women.

In January 2010, NHS organisations were asked to assess compliance with requirements for single-sex accommodation and further guidance was issued by the Welsh Assembly Government in August 2010. Action plans on progress in meeting hospital accommodation policies are required by 31 March 2011.

■ Initiatives undertaken with dignity and respect at their core

The Strategy for Older People in Wales was published by the Welsh Assembly Government in January 2003 and embraced the UN Principles for Older Persons.

It set out a significant agenda of work to address the need for improvements for older people in key services such as health, housing, social services and transport.

Its strategic aim was to help people to live longer healthier lives, to promote and improve the health and wellbeing of older people through integrated planning and service delivery frameworks and more responsive diagnostic and support services.

The **National Service Framework (NSF) for Older People in Wales** was published in 2006 and was adapted from the NSF for England. It set national standards designed to ensure that as people grow older they were enabled to maintain their health, wellbeing and independence for as long as possible, and receive prompt, seamless, quality treatment and support when required.

With regard to hospital care, the NSF says that when admission to acute hospital is required, access and assessment of need should be prompt and efficient, and ongoing treatment of care effective and responsive to the older person's needs.

An older person's hospital stay should also occur within a continuum of care, with a return to an optimum level of independence as the ultimate objective.

The NSF identifies that certain health conditions are more prevalent in older people, and specific measures to prevent and address these are provided in the standards on stroke, falls and fractures, and mental health in older people.

Appendices

Healthcare Inspectorate Wales (HIW) is currently reviewing the impact of the NSF on the quality of life of older people in Wales and aims to:

- Review progress in relation to the implementation of the NSF using specific cross cutting themes.
- Assess the maturity/performance of services provided for older people, promote practice worth sharing and support the drive towards continuous improvement.
- Identify national and local issues of concern and report accordingly.
- Assess whether the current plans and partnership arrangements are likely to achieve the timely delivery of the standards set out in the NSF and in so doing deliver better outcomes for older people.

In October 2009 HIW started a programme of unannounced **Dignity and Respect 'spot checks'** to wards and departments which provide services to people with mental health problems.

The focus of these spot checks was on how evident dignity and respect was in care and treatment; the quality and choice of food to meet dietary requirements; the suitability of the environment of care; and appropriate involvement, including of patients and carers, in care and treatment.

These spot checks showed that progress had been made in addressing issues related to dignity and respect, but areas for improvement remained. These included lack of privacy, lack of, or inadequate day space, lack of facilities or awareness of needs of patients with sensory impairment and patients or carers having little or no involvement in care or discharge planning.

They also found evidence of poor provision of personal professional development systems and training, and inadequate staffing levels.

Appendices

In 2007, the **Welsh Assembly Government** launched a **Dignity in Care** programme and taskforce, which have led to the development of local plans to address those aspects of care which might undermine patients' dignity.

The **Royal College of Nursing's 'Dignity: at the heart of everything we do'**⁴³ aimed to give support and direction to the UK's nursing workforce during delivery of care for patients and clients of any health status in every setting. It started with the premise that when dignity is absent from care, people feel devalued, lacking control and comfort. They may also lack confidence, be unable to make decisions for themselves, and feel humiliated, embarrassed and ashamed.

Providing dignity in care centres on three integral aspects: respect, compassion and sensitivity:

- **Respecting** patients' and clients' diversity and cultural needs; their privacy - including protecting it as much as possible in large, open-plan hospital wards; and the decisions they make.
- Being **compassionate** when a patient or client and/or their relatives need emotional support, rather than just delivering technical nursing care.
- Demonstrating **sensitivity** to patients' and clients' needs, ensuring their comfort.

There are several initiatives led from the **third sector** in Wales which also aim to improve the ways in which the NHS meets the needs of vulnerable patients.

For example, **A Dignified Revolution**,⁴⁴ set up in 2008, is focused on ensuring that the dignity and respect of older people is a key priority for all health and social care professionals, and encouraging the general public to challenge rather than tolerate unacceptable attitudes and inappropriate care.

NOTES:

43. <http://www.rcn.org.uk/newsevents/campaigns/dignity> and http://www.rcn.org.uk/newsevents/news/article/wales/dignity_at_the_heart_of_nursing_care

44. <http://dignifiedrevolution.org.uk/>

Appendices

In its publication, **Opportunities and challenges - Our ambition for public policy in Wales**,⁴⁵ Age Cymru argues that the dignity and human rights of older people must be placed at the centre of health and care services.

When older people enter a healthcare setting, they should be fully involved in decisions about their healthcare and responded to in a positive manner.

Older people should be able to expect single-sex accommodation, including access to single-sex showering and toilet facilities, and privacy when discussing treatment or being examined.

Good communication should be a priority and people should not feel patronised or ignored.

Older people have repeatedly told them that more support should be provided for personal care in hospital and that nurses should be enabled to spend more time caring for patients.

NOTES:

45. Age Cymru (2010) *Opportunities and challenges - Our ambition for public policy in Wales* Cardiff: Age Cymru

Appendix 3: Panel of Inquiry – Our work

■ Terms of Reference

In order to provide a robust basis for the Commissioner's recommendations to public bodies in Wales, we were tasked with gathering evidence from across Wales about the experiences of older people in hospital, with particular regard to dignity and respect.

The key elements of our Terms of Reference were to:

- Request and collect evidence on the experiences of older people who have spent five or more consecutive days in hospital during the past 2 years (June 2008 - June 2010);
- Identify good practice in the treatment of older people in hospital.

We were supported by a secretariat drawn from the Commissioner's staff.

We met for the first time in June 2010 and held a further nine meetings over the next seven months, concluding our work in January 2011.

■ Outputs

Produce a report of findings and conclusions which will inform the Commissioner's final report and recommendations.

Appendices

■ Scope

During the early stages of our work we recognised the potential breadth and complexity of the Review and made a number of early decisions which narrowed the scope. These were:

- That evidence would be limited to non-clinical aspects of a person's care rather than medical decisions taken about treatment.
- That the Review would not cover psychiatric hospitals or wards; however, evidence from patients who have mental health conditions but whose primary reason for being admitted is for physical needs would be included.
- How and when individual users are engaged in discharge planning would be included in the Review, but the adequacy or otherwise of their discharge arrangements would not be covered.
- That transport to and from hospital would not be covered.

■ The Call for Evidence

We issued a public call for written evidence on 15 June 2010. The advantage of gathering evidence in this way was that it offered an opportunity for people to share their reflections on their experiences and to give honest feedback, free from any fear of reproach. The Call for Evidence was widely publicised through the Commissioner's newsletters, website and networks of stakeholders.

By the closing date of 16 August 2010, 182 pieces of evidence had been received, of which 163 were from older people, their relatives or carers. A copy of the Call for Evidence and a list of organisations which submitted evidence are provided in Appendices 5 and 6.

■ Hospital visits

As we were acting under the delegated authority of the Commissioner, we were able to utilise her powers under Section 13 of the Commissioner for Older People (Wales) Act. This meant that we had the right to enter premises (other than a private home) for the purposes of interviewing, with their consent, an older person, accommodated or cared for therein.

On this basis, between mid September and mid November 2010 the Panel of Inquiry conducted a series of sixteen hospital visits throughout Wales. The visits covered at least one district general hospital or one community hospital in each Health Board and Trust area (see Appendix 7).

During the site visits we spoke to over 200 older patients, relatives and staff in at least two different settings (where these existed): a Care of the Elderly ward; and an acute medical and/or surgical ward.

We chose to conduct announced rather than unannounced visits as our overriding objective was to gain the cooperation of patients, relatives and staff. The Health Boards and Trust were informed of the dates and locations of the visits around two weeks in advance.

By notifying the hospitals and wards we were able to promote our visit, providing information sheets for staff and patients with the aim of securing their goodwill and cooperation. We were not conducting an inspection or audit - that is a role for others.

We wanted to minimise any risk that our presence on the wards would result in distress or inconvenience to patients, or impact on the dignity of their care.

Planning the visits in this way also enabled us to schedule time with key members of staff who may not have been available at short notice.

■ Analysis

The Panel secretariat and the Welsh Institute for Health and Social Care (WIHSC), University of Glamorgan, analysed the evidence gathered as part of the Review. WIHSC also provided support to us during the drafting of our findings and conclusions. We reported our findings and conclusions to the Commissioner in January 2011.

■ Recommendations

Based on our findings, conclusions, and advice, and with consideration of the wider policy context, the Commissioner developed the recommendations set out in this report.

■ The members of Panel of Inquiry

Dame Deirdre Hine DBE FFPH FRCP

Chair. Former Chief Medical Officer for Wales, previous President of the Royal Society of Medicine and of the British Medical Association; current President of the Royal Medical Benevolent Fund.

Meg Edwards

Former Director of Nursing, involved in the work of Age Cymru.

Monty Graham MBE

Former nurse, patient representative for Powys Health Board, Chair of Brecon and Radnorshire CHC, and carer.

Nicky Hayes

Consultant Nurse for Older People, Kings College Hospital, London; Clinical Champion for implementation of the National Service Framework for Older People and Dignity in Care lead.

Meirion Hughes

Former Director of Social Services and former acting Chief Executive of Denbighshire County Council; previous Chair of Denbighshire LHB.

Dr Charles Twining OBE

Clinical Psychologist, former Head of Psychology and Counselling for Cardiff and the Vale NHS Trust.

Appendix 4: Organisations subject to the Review

■ Health Boards

- Aneurin Bevan Health Board
- Abertawe Bro Morgannwg University Health Board
- Cardiff & Vale University Health Board
- Hywel Dda Health Board
- Cwm Taf Health Board
- Betsi Cadwaladr University Health Board
- Powys Teaching Health Board

■ NHS Trust

- Velindre NHS Trust

Appendix 5: Call for evidence



The poster is titled "Call for evidence: Dignity and respect in hospitals" and is from the Older People's Commissioner for Wales. It features a photograph of an elderly woman smiling. The text asks for evidence on the treatment of older people in hospitals and lists various areas of interest such as privacy, communications, food, and hygiene. It also provides contact information for the Commissioner.

Older People's Commissioner for Wales
Comisiynydd Pobl Hŷn Cymru

Call for evidence: Dignity and respect in hospitals

Are you an older person, or a relative, carer or friend of an older person, who has been in hospital for more than five consecutive days within the last two years?

The Older People's Commissioner for Wales is undertaking a Review on whether older people are treated with dignity and respect whilst in hospital.

What we want to know
We want to find out about **your experiences, both good and bad, when you are in hospital as an in-patient.** This may include:

- **Personal privacy**, including issues with mixed sex wards and facilities
- **Communications**, including how people are informed about, and involved in decisions about their care, the type of language used and terms of address
- **Food and nutrition** including offering and respecting choice, identifying and providing appropriate assistance
- **Personal hygiene** such as condition of hospital bathrooms, assistance with washing if appropriate, and the use of incontinence pads
- **Managing end of life care**
- **Recognising older people in all their diversity**
- **Planning for discharge** including when to plan and how this is communicated
- **Autonomy and identity** including access to personal items such as glasses and false teeth and personal possessions
- **Awareness of individual rights** and understanding of how to complain
- **Any other examples of good or bad practice related to maintaining dignity and respect.**

The Panel of Inquiry will **not** cover clinical diagnosis or treatment, the transportation of people to and from hospital, or discharge arrangements beyond hospital.

Recommendations to improve situations and respect and to spread good practice.

Four pages or 1500 words. You are encouraged to provide evidence in Welsh if you are able. If you should decline this will not affect your participation in the Review.

oplewales.com

5 August 2010

Some of the information you provide in part or in full may be published. However, we appreciate that some of the information you provide may be of a sensitive and highly necessary nature and we will take necessary steps to anonymise the information that we consider to be sensitive.

If you feel that your information is not suitable for public release, it will not be published. If you would like to discuss your information, please contact the Commissioner for Wales.

oplewales.com or by telephone

■ Call for evidence: Dignity and respect in hospitals

The Older People's Commissioner for Wales is undertaking a Review on whether older people are treated with dignity and respect whilst in hospital.

The aims of the Review are:

- to consider older people's experiences, both good and bad, when they are hospital in-patients;
- to make practical recommendations where people are not treated with dignity and respect; and
- to spread good practice where they are.

The Commission has established a Panel of Inquiry, chaired by Dame Deirdre Hine, to take evidence about the experiences of older people in hospitals.

Appendices

The Panel is now seeking written evidence from older people who have been, or are in, a general or community hospital. The Panel would also welcome evidence from older people's families and friends, carers and organisations working with and for older people from all sectors, including statutory and voluntary organisations, trade unions and professional associations about the experiences of older people whilst they are in hospital.

Evidence should relate to hospital stays of more than five consecutive days and be based on experiences within the last two years.

The Panel wishes to receive evidence on a number of issues and would be grateful if you could respond to any or all of the points below which apply to your circumstances or interests:

- Personal privacy, including issues with mixed sex wards and facilities.
- Communications, including how people are informed about, and involved in decisions about their care, the type of language used and terms of address.
- Food and nutrition including offering and respecting choice, identifying and providing appropriate assistance.
- Personal hygiene such as condition of hospital bathrooms, assistance with washing if appropriate, and the use of incontinence pads.
- Managing end of life care.
- Recognising older people in all their diversity.
- Planning for discharge including when to plan and how this is communicated.
- Autonomy and identity including access to personal items such as glasses and false teeth and personal possessions.
- Awareness of individual rights and understanding of how to complain.
- Any other examples of good or bad practice related to maintaining dignity and respect.

Appendices

The Panel of Inquiry will not cover clinical diagnosis or treatment, the transportation of people to and from hospital, or discharge arrangements beyond hospital.

Given the anticipated volume of responses to the Inquiry, we would appreciate it if written evidence does not exceed four pages or 1500 words. Evidence is welcome in the language of your choice.

The Panel of Inquiry will be taking oral evidence in the autumn so it would be helpful if you could indicate in your submission whether you would be prepared to give oral evidence, if invited.

Submissions should be sent to ask@olderpeoplewales.com or to:

Delyth Lewis
Secretariat to the Inquiry Panel
Older People's Commissioner for Wales
Cambrian Buildings
Mount Stuart Square
Cardiff CF10 5FL

Submissions should arrive no later than Monday 16th August 2010.

Appendix 6: Organisations that submitted evidence

■ Written evidence was received from:

Individuals

- 163 older people, their relatives or carers.

Organisations

- A Dignified Revolution
- Age Concern Cardiff & Vale
- Age Concern Gwent Advocacy Service
- Age Cymru
- British Geriatric Society Cymru Wales
- Cardiff & Vale Community Health Council
- Carers Wales
- Healthcare Inspectorate Wales
- Neath Port Talbot Council for Voluntary Service
- Royal College of Nursing Wales
- Vale of Glamorgan Older Peoples' Strategy Forum Health Group
- Welsh Language Board

Health Boards

- All seven Health Boards in Wales submitted written evidence.

Appendix 7: Hospitals visited by the Panel

- Barry Hospital
- Brecon War Memorial Hospital
- Bronglais General Hospital
- Cimla Hospital
- Colwyn Bay Community Hospital
- Morrision Hospital
- Mynydd Mawr Hospital
- Nevill Hall Hospital
- Prince Charles Hospital
- South Pembrokeshire Hospital
- St Woolos Hospital
- University Hospital of Wales, Cardiff
- Velindre Hospital
- Wrexham Maelor Hospital
- Ysbyty Bryn Beryl
- Ysbyty Cwm Rhondda

Appendix 8 Diversity research undertaken

Despite receiving a wide range of submissions from individuals and organisations representing the interests of older people, the Commissioner was concerned that she lacked sufficient evidence from older people from minority ethnic communities and from older lesbians, gay men, bisexual people, and older transgendered people about their experience as hospital in-patients.

The Commissioner therefore asked Dr Alison Parken to seek out any established research and conduct meetings with key third sector contacts to gather any pre-existing knowledge.

■ An incomplete picture

The number of older people from minority ethnic communities who have been recent hospital in-patients is both small and disparate. Self-identifying older lesbian, gay, bisexual, and transgendered people are also largely invisible within in-patient hospital services.

This in part may explain the paucity of empirical and anecdotal evidence relating to the treatment of cultural and identity issues within hospitals. Nonetheless, this is a glaring gap in our knowledge.

■ Equality Impact Assessments

In January 2010, the Assembly Government published a detailed Equality Impact Assessment associated with **‘Putting things right – a better way of dealing with concerns about health services.’**⁴⁶

This highlighted evidence received according to protected characteristics, concerns about language, and interpreter ability to relay medical terminology to some members of minority ethnic communities.

Unfortunately, this did not address wider cultural concerns. This mirrors our experience of hospital visits where diversity issues were limited almost exclusively to language choices and barriers.

NOTES:

46. Welsh Assembly Government (2010) ‘Detailed Equality Impact Assessment: Putting Things Right – a better way of dealing with concerns about health services, Directorate General for Health and Social Services, Cardiff: Welsh Assembly Government

Appendices

■ Sexual orientation

In relation to sexual orientation, a survey of people of all ages by Stonewall Cymru⁴⁷ highlighted that a fifth of those surveyed expressed concern about treatment in healthcare settings. Concerns about discrimination in local hospitals, and feeling uncomfortable when visiting one's partner in hospital were raised. Although samples were relatively small, older people over the age of 51 were more likely to report discrimination.

The Welsh Assembly Government issued a Circular in 2008 entitled **'Raising awareness of the needs of lesbian, gay, and bisexual people (LGB) when accessing health services'**⁴⁸ which stated that LGB people should be treated with dignity and respect 'because of their differences and not in spite of them'.

The guidance recognises the importance of privacy and confidentiality issues in relation to patient monitoring and involvement, the nomination of 'next of kin' status with regard to information giving and decision-making.

The Circular makes clear that information should only be sought by healthcare workers according to the patient's own wishes. Language and attitudes should be such as to make same sex partners feel at ease with being open about their relationships so that they can be supported at times of illness or crisis. The Circular encourages the use of diverse images around hospitals including the portrayal of same-sex partners.

■ Older Trans people

Empirical evidence collected in England highlighted concerns amongst Trans people who had been allocated to wards on the basis of their birth rather than their chosen gender, and concerns about inappropriate references to the patient's gender identity within earshot. A detailed Equality Impact Assessment by the Welsh Assembly Government is critical of the tendency to label Trans people as 'bisexual'.

NOTES:

47. Williams M L and Robinson A (2007) Counted In: A report for Stonewall Cymru and the Welsh Assembly Government SME Equality Project Cardiff: Cardiff University
48. Welsh Assembly Government, Welsh Health Circular (2008) 031: Raising awareness of the needs and rights of lesbian, gay and bisexual people when accessing healthcare services in Wales

■ Members of Black and Minority Ethnic Communities

Whilst there is significant clinical data available on diseases and conditions and prevalence amongst minority ethnic communities, there appears to be little relevant data on in-patient stays. The lack of information relating to people from minority ethnic communities is both surprising and a cause for concern.

From a basic literature search, there appears little attention paid to issues such as cultural and religious requirements for gendered services, maintaining modesty especially amongst some minority ethnic women, meeting the cultural and religious needs of patients and visitors, and addressing nutritional issues both in relation to the content and timing of food.

■ Conclusion

There is a real scarcity of research and evidence in Wales highlighting the experience of older people in all their diversity as hospital inpatients.

There are encouraging steps being taken in third sector organisations to help plug gaps in knowledge, but the provision of services now and in the future requires a greater understanding of the increasing diversity of patients. Research, awareness raising, training and guidance would all be useful steps to take.

The Human Rights agenda is relevant for all patients and has a particular resonance in relation to diversity considerations.

Older people in all their diversity must be included within NHS patient experience arrangements.

Appendix 9: Good practice

The Panel discovered many commendable examples of practice which contributed to patients' dignity and well-being. A selection of these are described below. The practices captured have not necessarily been validated as good and notable and should be read in this context.

Many of these encouraging developments were still only found on individual wards, and have yet to be adopted throughout the hospital or Health Board/NHS Trust. Many initiatives were at a pilot stage and the way forward for some hospitals was not clear. These programmes also depended very much on the proactive nature of the ward staff and their team. Health Boards and Trusts need to ensure that such innovation is encouraged, and to ensure that good practice is disseminated and adopted universally.

1. Ward-based routines

Some hospitals have introduced a number of strategies to help improve patients' dignity and respect:

- Red Pegs on the curtains to protect individual privacy and dignity.
- A Dignity Code, a simple concept based on the Green Cross Code of Stop, Look, and Listen. In the single cubicles the notice is on the door. A **Red** traffic light symbol will provide a visual picture to remind staff to Stop when care is being given, **Amber** - Look and Listen, and **Green** - Can Access.
- The Well Organised Ward (WOW) means that everything is in its place and labelled to save a lot of wasted time, this time can then be spent with the patient. Everything is geared to improve the patient's experience.

These initiatives of good practice were commended by some of the panel members and especially the concept of the 'WOW' principles of a Well Organised Ward that are on display in these wards. This and other initiatives allowed patients and staff to feel confident about the care provided. It was also noted that from both the patients' reports, and from observations on the various wards, these initiatives have produced an environment in which patients are treated with empathy and respect as individuals.

2. Volunteering schemes

Some hospitals have volunteer schemes to assist with patients' needs and it has been noted that the use of volunteers and their relationship with patients and staff has been very well received:

Examples:

- **Red Robin scheme**, which is a volunteer scheme of some twenty to thirty people who work on the ward - one person or two people each day, seven days a week from approximately 8:30am to 2.30pm carrying out a range of duties under the direction of the ward manager.
- The **'Friendly Face at the Bedside'** initiative was a three year Big Lottery funded project with the aim of introducing one hundred volunteers to support patients in hospital. The volunteers support patients and their families, providing company, encouragement and running errands, as well as supporting staff.

The volunteer schemes have worked well, successfully involving a range of volunteers who have been well accepted as part of the multi-disciplinary team. Moreover, patients in some of the hospitals were very complimentary about the volunteers and how they were able to spend time with them.

3. The Patient Story Initiative

More recently, some hospitals have introduced the **'Patient Story Initiative'**. The rationale behind this is to gather patients' experiences in their own words. These narratives can help develop understanding among those delivering care - they can interpret the narratives using their own clinical and professional knowledge and experience to create better ways of meeting patients' and carers' needs.

Nurses are trained in how to encourage patients to tell their story and are then allocated to wards other than those they work on to collect accounts of patient experience and report on these.

One hospital visited gives patients what is called a Patient Personal Daily Diary for patients to record and make comments.

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4. Protected meal times

The Welsh Assembly Government requires hospitals to implement protected meal times in appropriate clinical settings. Some hospitals have implemented protected meal times in many settings and it has been viewed as a positive action for the patients as they can eat without interruption, and with support, giving them the best chance of getting the nutrition they need.

It was noted by many staff that protected meal times provided a quiet and relaxed atmosphere in which patients are afforded time to enjoy meals. They emphasised the importance of meal times as part of care and treatment for patients:

“Protected meal time introduction has been welcomed and should improve how we meet the nutritional needs of patients. We help patients to make a good choice from the menus.” (Staff)

5. Patient safety calendar

One ward has adopted a “safety calendar” which records the number of cases of falls, pressure sores, MRSA and CDT each month. This is a type of scorecard by which the team measures its performance.

6. The Digni Robe

One hospital visited has also introduced the “Digni robe” for use by patients who are being transferred on the hoist to the bathroom. The robe’s function is to cover up the patient’s front and back completely and a towel is placed over the legs.

7. Ward Physio-Gym

One hospital has made available a physio-gym on the ward. As well as allowing for better monitoring of patients’ physical activity levels, it is also a way of preserving patients’ dignity and respect as they do not have to leave the ward and are afforded more privacy while receiving their treatment.

8. Welsh Language Board logo

In order for patients to identify staff who can speak Welsh a Welsh Language Board logo has been introduced and embroidered on the uniform of Welsh speaking staff. Discussions between patients and nurses can be highly sensitive, and patients often feel vulnerable,

therefore it is of the utmost importance that patients can discuss matters through the language of their choice.

By seeing this logo on a member of staff's uniform, a patient will be reassured that their language choice is available.

9. The multi-disciplinary team

During the hospital visits there were numerous comments from all the staff interviewed about the success of the multi-disciplinary team and how its members have formed a close professional relationship. Multi-disciplinary communication is viewed by staff as extremely positive, especially the multi-disciplinary meetings.

Team work within the hospitals and with outside departments is believed to be effective. Overall, it was noted that the multi-disciplinary team plays an increasingly important role in the management and care of older patients, providing support to patients and families and helping them adapt to illness and treatment plans:

“Our multi-disciplinary meetings include a range of other skills and experience where the focus is on the need of the individual patient. These meetings are very democratic and we are all open to challenge no matter what our role in the team may be.” (Staff)

10. Ticket Home scheme

When the patient is admitted to the ward there will be a “Ticket Home” card displayed close to their bedside for the patient and their relatives or carers to refer to for an estimated date for discharge.

The purpose is to help the patient and the healthcare team to communicate plans for discharge and to ensure that it is safe and timely.

Members of the healthcare team each indicate when they are satisfied that the patient is ready and able to leave hospital.

Appendix 10: Definitions and abbreviations

Definitions

In-patient	For the purposes of this Review, the term in-patient relates to someone whose hospital stay was for more than five consecutive days, and whose primary reason for admission was a physical condition.
Older person	The Act of Parliament which established the Older People's Commissioner defines an older person as someone who is aged 60 or over and who satisfies at least one of the following criteria: (a) is ordinarily resident in Wales; (b) is receiving a regulated service in Wales; or (c) is receiving relevant services from, or on behalf of, certain bodies named in the Act.
Panel of Inquiry	Set up by the Commissioner to collect evidence directly from older people, the Panel's findings formed the basis on which the Commissioner made her Recommendations.
Review	Under section 3 of the Commissioner for Older People (Wales) Act 2006 (COP(W) Act) the Commissioner can conduct a Review into the discharge of functions of any of the bodies referred to in section 3, and the impact of the discharge of those functions on older people. A Review is conducted with an eye to providing constructive criticism, correction or praise. A Review will reflect the general functions of the Commissioner as set out in section 2 of the COP(W) Act 2006: promote awareness, eliminate discrimination, encourage best practice and review the law.
Ward Manager	The ward based clinical nurse with responsibility for the day to day running of the ward: common job titles included Charge Nurse, or Ward Sister.

Appendices

Abbreviations

BMA	British Medical Association
CDT	Clostridium Difficile Toxin
CHC	Community Health Council
COP(W) Act	Commissioner for Older People (Wales) Act 2006
FoC	Fundamentals of Care
HCSW	Healthcare Support Worker
HIW	Healthcare Inspectorate Wales
LGB	Lesbian, gay and bisexual people
MRSA	Methicillin-resistant Staphylococcus Aureus
NLIAH	National Leadership and Innovation Agency for Healthcare
NSF	National Service Framework
OPCW	Older People's Commissioner for Wales
RCN	Royal College of Nursing
WAG	Welsh Assembly Government
WIHSC	Welsh Institute for Health and Social Care