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# Learning from Trusted to Care

Ministerial Unannounced Older Persons  
Mental Health Wards Spot Check Visits



## All Wales Report

# **LEARNING FROM TRUSTED TO CARE**

## **MINISTERIAL UNANNOUNCED SPOT CHECK VISITS – OLDER PEOPLE’S MENTAL HEALTH WARDS**

### **ALL WALES REPORT**

#### **FOREWORD**

Foreword by Professor June Andrews, Donna Ockenden, Professor Philip Routledge and Kim Williams

We were pleased to be asked by the Minister for Health and Social Services to oversee a series of unannounced 'spot check' visits to older persons mental health wards in Wales in the wake of the report "Trusted to Care" and in light of the more recent findings from the Tawel Fan Ward. The spot check visits focused on seven fundamental aspects of care;

- eating and drinking (nutrition and hydration)
- use of restraint (locking doors or holding people to prevent harm) and safeguards (legal requirements to assess people ability to make decisions or protect them if they have a mental disorder)
- the use of medication; giving patients their medication and prescribing of sedatives and antipsychotics
- continence and personal care (toileting)
- daily activities
- relatives and carers and their involvement in care
- culture and leadership

We were allowed input into the methods used at a very early stage and our recommendations were acted upon. In particular it was important to us that the clinical judgement of the inspection team was exercised, rather than relying exclusively on checklists. We note that these visits were conducted to a high standard by experienced staff.

This report reflects the issues identified during the spot checks and highlights areas for improvement. While we are confident that progress has already been made, there is room for further improvement.

The examples of good practice highlighted through the older persons' spot checks should be noted by the NHS in Wales and any learning shared with other providers of healthcare to support improvement in every setting. We look forward to the changes being implemented in the care of older people and we expect all healthcare organisations in Wales to embrace the opportunities for learning that this process has provided.

## MESSAGE FROM THE REVIEW TEAM

The review team members thank the Minister for Health and Social Services for the opportunity to undertake the unannounced spot check visits across NHS Wales. We commend this report to the Minister for Health and Social Services in order to help inform and improve the future care of older people in Wales.

In summary, the spot check process identified variation in practice across older people's mental health wards in Wales. Although many wards demonstrated excellent or good standards of care, others were only adequate or required improvement. These were brought to the immediate attention of the relevant local health board.

The spot checks process set out seven areas to be scrutinised by the review teams. Within the areas scrutinised, we identified some significant issues requiring urgent attention but we also observed examples of noteworthy practice. The relevant NHS organisations have been asked to address immediate issues highlighted for concern as well as the other matters identified (as detailed in the findings section of the individual reports).

We thank patients, relatives and carers and the staff who gave time to share their views, experiences and information to inform the spot check findings.

## THE SPOT CHECK PROCESS

### Developing the Approach

This report should be read in conjunction with the details of the individual reports for each of the 22 wards. These can be accessed by following the hyperlink to the Trusted to Care area of the Welsh Government website<sup>1</sup>, where there are more details of the Trusted to Care Programme. The spot check visits were designed to establish whether care for older people on mental health wards in our hospitals was being provided safely and compassionately and to provide citizens with information about their local services.

As with the initial spot checks which followed the publication of *Trusted to Care*, professional and independent advice on the methodology and process was provided by Professor June Andrews, Mark Butler, Donna Ockenden and Professor Philip Routledge. In addition, advice was sought from Kim Williams, Consultant Psychologist at Cwm Taf UHB. Their engagement informed and strengthened the process.

The initial tasks involved in setting up the spot check programme included the development of the tools that were used to assess the quality of care in each of the seven areas. Looking at planning the spot check schedule and setting up the team was undertaken in this initial stage.

### Tools

The assessment tool used by the spot check teams consisted of a detailed list of questions and prompts designed to test each of the seven areas. These supported review team members in applying their clinical judgement to what they saw in practice. Examples of the types of questions and prompts are listed below:

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<sup>1</sup> <http://gov.wales/topics/health/nhswales/spot-checks/mentalhealth?lang=en>

### Continence Care and Personal Care

Are toilets and bathrooms in good condition, within easy reach for the patients and is there appropriate signposting?

Are patients being supported with their basic continence needs?

What is the general appearance of the patients?

Are patients encouraged to wash themselves? Do they have their own toothbrush? Do they have their own dentures?

Are relatives and carers encouraged to support continence and personal care?

Are patients encouraged to move around to maintain their mobility?

Are patients wearing their own clothes? Do they have personal items such as their own possessions and photos with them?

### Nutrition and Hydration

Is there a sample menu?

Are there photographs and is it in large print?

Are patients drinking regularly? Is fresh water, tea etc readily available and within reach?

Do any patients look dehydrated?

Are there protected meal times? Are relatives and carers encouraged to be present at meal times?

Are patients given a choice of food and asked what they would like to eat. Is it given to them?

Are patients encouraged to eat and drink for themselves?

Are staff involving patients in the preparation of food?

Are patients supported to make meal choices based suitable to meet their nutritional needs, personal and cultural preferences?

### Use of restraint and application of appropriate safeguards

What kinds of restraint/safe holding are used on this ward?

Do patients have a formal assessment of capacity?

Is the restraint used within mental health and mental capacity legal frameworks?

How often is the use of restraint on a patient reviewed?

### Daily activities

Are patients meaningfully engaged in activities that provide physical and mental exercise?

Is there a programme of activities and evidence that they occur?

Are patients engaged in therapeutic activities linked to the purpose of their admission e.g. evidence based psychological therapies, reminiscence, cognitive stimulation therapy, exercise regimes based on advice from any of the therapeutic professions?

### Medication, sedation and antipsychotic prescribing

How often are these medications assessed and reviewed in individual patients?

Are patients offered and given appropriate pain relief?

What information is provided about patients' medication to relatives and carers?

What is the extent to which covert medication is used? If it is used, how is its use/appropriateness documented and understood by staff and is its use kept under regular review?

What non-pharmacological methods are used to calm or distract patients?

Is resuscitation equipment available on the ward?

How quickly are acute physical health issues dealt with?

### Relatives and carers and their involvement in the care of their loved ones

Is there evidence that relatives and carers are engaged in patient care, i.e. care and treatment planning and review?

Is there information readily available about the patient's illness and likely outcome, access to advocacy and making complaints?

Do relatives and carers know when ward rounds take place?

Is there freedom to visit at any time?

### Culture and leadership

How often do doctors attend the ward?

What training has been undertaken by staff on the ward during the last 12 months? (and how often are training/personal development opportunities provided?)

Are there regular staff meetings and do ward management communicate messages from senior staff?

What are the staff supervision arrangements?

What is the rate of staff turnover?

Do you feel confident and supported to do your job?

Are you able to raise concerns and is there evidence that they are responded to?

Does this ward have any staff vacancies and if so, for how long have the posts been vacant?

### **Visit Schedule**

The remit for developing the spot check visit schedule included some key principles. It had to:

- Ensure all visits were unannounced;
- Ensure that review team members did not visit their own Health Boards;
- Cover around half of the older people's mental health wards in Wales;
- Cover the patient day, from early morning to late at night, over seven days of the week;
- Include reflection days for the team to review findings and ensure consistency in the process; and
- Support the health and safety of the spot check team members.

On this basis, the schedule covered a five-week period from the 20 November to 18 December 2014. The spot check visits took place at any time of the day between 6am and midnight, on weekdays and weekends and all were unannounced. This allowed the spot check teams to observe patient care throughout the day and late into the evening, including part of each shift period.

The schedule was confidential and in order to protect the unannounced status of the spot check visits, only two individuals had access to the schedule. The spot check team was made aware of the hospital site and ward they were visiting the day before their arrival on site.

Spot checks were undertaken in all Health Board areas and in total 22 of the 51 older people's mental health wards in Wales were visited.

## Setting up the Review Team

Appendix 1 lists members of the review team.

In line with the spot checks in general wards that followed the publication of *Trusted to Care*, a team of senior individuals was needed to undertake the spot checks of older people's mental health wards. The aim was to identify individuals who met the following criteria:

- Some members to be current Healthcare Inspectorate Wales (HIW) reviewers.
- In current clinical practice or retired within the last three months.
- Senior healthcare professionals.
- Experience of working with older people.

The spot check team comprised senior older people's mental health nurses (currently practising); older people's pharmacists and occupational therapists with a range of skills, knowledge and experience as well as input from an old age psychiatrist. Three of the four team leaders for this programme of spot checks had also been team leaders in the earlier round.

Ahead of the spot checks being carried out, a training day was arranged with the team leaders and team members. The purpose of this session was to discuss the inspections and confirm the process arrangements for the visits.

### Taking action on concerns

As part of the preparation, training took place on how the review team would deal with any concerns found. A process was put in place whereby (dependent on the level of concern found), there would be communication at a local level which would be reported as part of the summary of findings at the end of each visit. More serious concerns would be immediately escalated to the Health Board Executive on-call and staff overseeing the spot checks within Welsh Government.

Because patient safety and dignity are paramount, any necessary actions were put in place immediately to address any care concerns thought to be of significant concern. Any immediate actions requested were then followed up with the organisation concerned the next day to seek assurance that immediate improvements were being put in place.

### Feeding back on findings

Immediate feedback was provided to a Health Board Executive after each spot check by the review team leader. The feedback sessions were often attended by a range of staff who were keen to learn the outcome of the spot check.

Health Boards were then asked to confirm that any actions and improvements identified were being addressed. The findings from each visit have been shared with HIW to help inform and focus their future Dignity and Essential Care Inspection (DECI) and spot checks programme.

The Welsh Government have made it clear that the Health Boards will wish to satisfy themselves as to the quality and safety of services in the wards which have not been spot checked by applying the same methodology.

Each Health Board has received individual hospital site reports for all areas visited. Public reports are available via the Spot Check Reports<sup>2</sup>.

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<sup>2</sup> <http://gov.wales/topics/health/nhswales/spot-checks/mentalhealth?lang=en>

## **THE FINDINGS**

Visits revealed areas of good and excellent practice across Wales, they also revealed some areas where immediate concerns were raised by the team. Those concerns were raised with the local health board (LHB) in oral feedback from the inspection and then in writing. All LHBs have confirmed to the Welsh Government that they have addressed those concerns identified. Other issues that the LHBs needed to address and consider in the short to medium term were also identified in the individual feedback to the Boards.

The teams identified considerable variation in practice both within and between individual wards in Health Board areas. They found staff teams were doing their best to provide good quality care despite a number of challenges, some of which were perceived by staff to be beyond their control. The checking team highlights that a key element in taking forward the learning from the spot checks is for staff and organisations to have in place robust mechanisms for reporting and escalating all concerns about patient care including any currently perceived to be outside the control of the staff.

The Review team found that even where these mechanisms and protocols already exist staff could find it difficult to use them effectively and may need a greater awareness of the right mechanism to raise concerns. Ensuring they felt valued and listened to and that there was “ward to board” and “board to ward” open effective communication was important to staff. There were perceptions in some clinical areas of the staff feeling less valued and engaged than in other clinical areas, and this needs to be addressed.

It is worth noting that everywhere staff welcomed the spot check visits and told the teams it felt good to be heard, and welcomed discussing the findings of the visits. Senior management teams reported they found the work helpful and informative

General lessons to be learnt across Wales are identified below for further action by the NHS.

Good use of evidence based practice was seen in a number of areas and some innovative practice identified. Staff often had no way of knowing what best practice is, and this needs to be remedied. It was apparent that some staff found it difficult to share experiences and good practice even within their own health board. The all Wales approach to this method of practice improvement and development is limited although Welsh services are now being supported in sharing good practice by Public Health Wales and the 1000 Lives Improvement process. A community of practice for people working in older people’s mental health care has been established to provide a mechanism for health care staff to come together and consider evidence based practice and research.

### **The seven areas:**

#### **Continence Care (Toileting) and Personal Care**

Continence for individuals was normally managed using person centred approaches, with assessments routinely undertaken in most wards. Continence care, for the most part was delivered in line with the recommended guidelines in the “All Wales Continence Tool”. There were often clear signs on doors and a range of continence aids provided. Although wards overall smelled pleasant, a few locations had problems which were generally caused by laundry or some environmental issues. All wards had working toilets but the team found, in a small number of areas, single toilets that were out of order. Staff reported that timely repair can be problematic and this has a negative impact on patient care. (See the section on environment and maintenance). Access to a working washing machine was identified as important both for staff and family carers who on occasion might otherwise be asked to launder the patient’s clothes.

Almost all of the wards visited have evidence of person-centred approaches to care. The comfort, dignity and identity of patients was generally well addressed and maintained through ensuring that people had their own clothes, and toiletries and that they had some personal possessions around them. Some wards had better facilities than others including access to equipment such as specialised chairs. Only some had personal identifiers such as memory boxes by bedroom doors to remind individuals of their room location.

### **Nutrition (food) and Hydration (drinks)**

Patients showed no evidence of being thirsty or dehydrated. Flexible practice was noted in the majority of wards, where finger foods and snacks were available throughout the day and evening and generally there was good choice of meals. Wards had jugs of water or squash in communal areas and hot drinks were generally readily available. In some places there was also ready access to a kitchen where with support; patients could make their own hot drinks. Relatives were actively encouraged to support the patient in eating and drinking. The local reports provide more detail of good practice in nutrition and hydration. Unfortunately in a few areas, the ward routines were too rigid in terms of visiting hours and the support that families and friends could offer was not encouraged. (See section on family and carer involvement in care.) In some areas, the catering department appeared to have poor understanding of the needs of these patient groups and a greater focus on reducing food wastage than providing a good choice of nutritious meals.

### **Medication, sedation and antipsychotic prescribing**

Inappropriate use of antipsychotic medication was not identified as an issue in the majority of wards. In two wards patients were identified as potentially benefitting from the use of antipsychotic medication because all behavioural modification techniques were being used without success. At the time of the visit, over prescribing was questioned in two wards, but subsequent review suggested that the prescribing was appropriate.

In terms of hypnotic medicines (to help people sleep) or sedative medicines (to reduce agitation), 'as required' medication was used rarely. Only on very few wards did it appear that sedation was prescribed "as needed" for patients.

The use of covert medication (when medications are prescribed and given appropriately, but hidden in food or drinks to make it easier to administer practice) - was variable. Many wards have policies in place that govern such practice but in a number of other areas, the process for and understanding of its use was far less clear. This needs to improve.

Pain management practice, although not a formal topic for these spot checks, was noted to be good in some wards and was considered routinely if someone was agitated and assessed to be in pain but not able to describe their symptoms.

Problems with access to and the storage of medication were relatively common: there was almost universally room for improvement in relation to refrigerated storage and date checking. Guidance for medication refrigeration standards will shortly be issued across Wales so that this can be addressed across the NHS, prioritising areas of greatest risk.

Non-pharmacological interventions that are proven to reduce the need for medication such as activities and occupation were being used in the majority of wards but not everywhere; this is discussed further in the section on daily activities. However, there was little evidence that psychological therapies or psychosocial interventions specifically aimed at helping people to cope with their condition and reduce anxiety were being employed. These therapies have been shown to reduce distress either as an alternative or adjunct to

medication and are a fundamental part of any treatment plan. They may reduce the need for medication.

Generally, the administration of medication was in line with expected standards other than in isolated cases.

### **Use of restraint and the application of the appropriate safeguards**

Most wards were found to use appropriate documentation including care and treatment planning documentation. However in a small number of wards it was observed that documentation could be significantly improved. This has been drawn to the attention of the relevant health boards. Duplication of the same information for different purposes is highlighted as a major cause for confusion.

Formal safeguarding processes, including the application of and understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and the Mental Health Act 1983 and other safeguarding requirements, showed significant inconsistency in the quality of documentation to support the processes.

Processes for recording major decisions and how best interest processes are applied were not uniform. It was noted that sometimes this included decisions about end of life care. There was a lack of clarity in many wards as to who could or should speak with relatives or carers prior to the final decision being recorded by the doctor.

Similarly staff understanding of restraint or safe holding and its implications in the specific needs of older people who are frail was variable. While excellent practice was observed in some wards others showed a limited understanding of requirements and further training should be undertaken.

### **Daily activities**

The provision of activities is a fundamental part of providing care in older people's mental health wards.

While excellent or good practice was noted in many of the wards, there was discrepancy in the use of structured and unstructured regular activities as a key component of care. The lack of such activities was felt on some wards to exacerbate clinical need and distressed behaviours such as wandering. This is one of the key areas which must be addressed by LHBs. Having access to activities throughout the day improves quality of care for patients and also can free up time to care for nursing staff. Ensuring appropriate activities, in line with evidence based best practice, are being provided with advice and supervision from a range of professionals including occupational therapy and psychology is one of the key elements of learning from the findings.

On wards where there was ongoing access to 'failure free' activities, there appeared to be less behavioural disturbance which made the day to day experience of patients more pleasant and managing the wards easier.

Occupational therapy time to plan and support activities was seen as being essential for patients and freed up nursing time. Simple activities such as the accessibility of rummage boxes, singing and exercise were observed on some wards, as were involving patients in laying the table at mealtimes, tidying their rooms or serving drinks to other patients. These activities were felt to be important in promoting a positive culture of care.

Reminiscence and cognitive stimulation therapy were provided on very few wards. Evidence based psychological therapies such as these were not observed to be taking place as an integral part of the treatment provided in many units.

### **Relatives or carers and their involvement in the care**

The involvement of relatives or carers engagement was encouraged on the majority of wards and all wards had carer information available and visible. Visiting hours were often flexible with a few wards taking a more rigid approach. Wards where patients' needs were placed at the heart of their work were wards where there was considerable flexibility with routines. In practical terms most people were able to visit for most of the day and evening.

Relatives and carers were seen as a source of information on patients by the staff in all wards. Relative and carer involvement in terms of support at mealtimes was often welcomed in many wards but not in all. Volunteering was encouraged on some wards, reflecting that these wards were more open and transparent in their culture.

So that relatives and carers could be well informed about their family member's condition, admission information packs were available on some wards.

In some places, relatives and carers groups had been established and these were felt to provide much needed support to them. On those wards where carers were not fully engaged as part of the wider team supporting patients, further work needs to be undertaken.

### **Culture and leadership**

The spot checks revealed that most staff were doing their best to provide care in a compassionate way and in sometimes difficult circumstances. These circumstances include problems with the ward environment, the skill mix of the staff team, the need to cover vacancies with bank or agency staff or the inability to access training.

However in some wards, staff felt they were less valued than those working in other areas of mental health service provision or in other physical health areas, e.g. intensive care or cancer services. Working in mental health was sometimes felt to impact on career development opportunities. They also felt older persons mental health provision was less likely to be of interest to more senior Health Board management and this was identified by the teams as an issue to be addressed.

Wards were noted to function better where there was regular and predictable medical, occupational therapy and pharmacy support as well as easy access to other health professions notably psychology, physiotherapy, dieticians and speech and language therapy. A need was also identified for easy and rapid access to physical health care support for patients.

A strong multidisciplinary team with clear leadership and lines of accountability at ward and Directorate level was important to staff and where this was in place, there was an increase in the likelihood of good or excellent service provision. Those wards where deficiencies were identified have been advised to consider how this can be improved.

### **Additional areas for improvement**

Some observations were made which although outside the fundamental areas of care covered, were of such importance that they should be highlighted. They are similar in theme to those identified in the report on spot checks in general wards.

## **Environment and maintenance**

Often the simplest problems can cause great challenges in care provision. Most wards demonstrated that small maintenance tasks left undone were causing significant disruption to patient care, staff time and even placing burdens on families. This included families needing to take home soiled and wet clothes due to the lack of washing machine facilities.

Problems such as showers, toilets, washing machines and lifts being left in a state of disrepair were observed. These problems had been reported and, in some cases, no action had been taken to resolve them for many weeks. The result of these problems is that patients may be left longer between washes, and have problems accessing toilet facilities. In some areas, broken and damaged furniture was reported as being left uncollected for months. Delays are unacceptable and clinical staff need to be aware that they have responsibility to put in place measures to prevent such instances. A system of reporting environmental and maintenance issues to the Board should be in place.

Many wards have started to implement dementia or older person-friendly environments, and more needs to be done as funding for refurbishment becomes available. All areas should strive to provide a safe but homely environment with clear signage, art and activities which promote reminiscence and conversation and other evidence based changes such as contrasting toilet seats and adapted crockery and cutlery. There are a number of audit tools and sources of information that can be used to support the development of a dementia friendly environment. Stirling University and the Kings Fund are sources of information about creating dementia and older person-friendly environments. Health Boards should aim to undertake some form of audit so that they are clear what improvements can be made to help patients manage better in hospital.

## **Catering flexibility**

Providing food and drink for frail elderly patients with severe dementia demands different approaches to providing for people with acute illnesses. Breakfast and two square meals may well not be appropriate for many who take a long time to eat a large meal. In all areas nutritional needs were met and in many wards catering provision was very good. However ag catering facilities did not reflect some of the specific needs of frail elderly people in a few areas and, staff reported problems accessing appropriate food for patients at the right times, and more flexible catering arrangements were needed.

Many patients will need to eat smaller but balanced snacks over the day as well as a communal meal which may not be finished. Patients with dementia often benefit from free access to food and drink, and this may also be more appropriate. Patients need encouragement and practice to prepare food and drink for when they return home. Kitchen facilities in wards should therefore have this need in mind and be suitable to support patients in both their layout and the equipment provided.

## **ENGAGEMENT WITH RELATIVES AND CARERS**

In addition to the spot checks, the relatives and carers of those receiving care on spot checked wards were offered the opportunity to speak to a review team leader about their views and experiences of the care provided. Given the particular characteristics of patients with dementia and other severe and enduring mental illnesses, and their difficulties in speaking for themselves as a result of their impaired capacity, the views of relatives and carers is especially important. The opportunity to speak to a review team leader was advertised via a notice which was added to ward noticeboards and a letter issued by Health Board staff to a random selection of relatives and carers on spot checked wards.

A questionnaire was designed which included nine questions:

- What has been your experience of having your relative/friend cared for on X ward?
- What do you think of the care provided?
- Have you been involved in the development of care and treatment planning for your relative and its review?
- Have you been asked to provide a personal history of your relative?  
(including key areas of the patient's life e.g. family structure and relationships, occupation, interests, preferences etc.)
- Have you seen information e.g. about how to make complaints, the dementia helpline, Alzheimer's Society and Age Cymru etc. on ward notice boards or elsewhere?
- Have you been given information or spoken to about your relative's disease/illness and its likely outcome?
- Do you know when the doctor's ward rounds are and when any other staff involved in your relative's care are on the ward?
- When can you visit?
- What sort of things do you feel the staff are happy for you to help with?

Twenty two relatives and carers took up this opportunity. The majority of respondents spoke very positively about the standard of care the patient was receiving. While some spoke of low staffing levels (including one relative/carer writing to the Board about this issue) and difficulties with one or two staff members, these comments were the exception and not the norm. The staff were felt to be caring, hardworking, trustworthy and knowledgeable about the patient's needs. The relatives and carers also felt involved in and had the information they needed about their loved ones care.

The concerns that were raised related to the poor quality and range of food and the poor quality of the ward environment in terms of 'dementia friendliness', decoration, maintenance and repair.

The team recognises that it is important to consider that future developments use an approach that is committed to co-production with both patients, families and carers

## **TAKING FORWARD THE LEARNING**

We identified areas for improvement across each of the methodology areas.

### **Continence care and personal care**

Work needs to continue to make it easier for older people to access toilet facilities on wards. Good practice such as proper signage, contrasting coloured toilet doors and contrasting toilet seats to help people find and use toilets easily should continue to be increased as refurbishment funds or smaller pots of funding are identified.

Continence assessments should always be undertaken and a range of continence pads should always be available and stored discretely.

Patients and relatives or carers should be encouraged to provide familiar materials such as photographs in the patient's room of themselves, families and friends, not only to help them find their rooms but also to help staff appreciate and get to know the person. Examples of good practice should be used more widely.

### **Nutrition (food) and Hydration (drink)**

Better practice was observed in some areas over others. All wards should make drinks freely available throughout the day as well as regular rounds when people are actively offered drinks and assistance is offered.

Snacks and finger foods should be available throughout the day as well as regular, sit down hot meals which encourage social interaction.

The use of named place mats with photographs to help patients recognise their place and any dietary requirements such as soft food, culturally appropriate food and likes and dislikes was a simple idea which helped staff to better know the patients and to manage their nutritional needs more appropriately.

### **Medication, sedation and antipsychotic prescribing**

No evidence of over-prescribing of medication was found and administration practice was generally good. Care should be taken to record the reasons for prescribing any sedative medication and for how long in line with NICE guidance.

In some areas letting patients sleep and wake at their own pace in the morning was encouraged and staff and other were encouraged to "hush" to ensure that patients were not woken to fit in with staff routines.

Work should be undertaken to ensure the provision of effective, regular and mental health-specific pharmacy input into all multidisciplinary teams.

Work should be undertaken to review policies and practice in relation to covert medicine administration to ensure that practice is consistent with guidance from NICE and professional bodies

Most areas will need to review their medication storage including refrigerated storage and management of date expired medication. Guidance on refrigeration equipment and standards will be issued to LHBs shortly.

In some areas the inclusion of a photograph of the patient attached firmly to his or her medication chart can help staff who do not know patients well. This as well as identification band checking was particularly important if bank or agency staff might be working on the ward

### **Use of restraint and the application of appropriate safeguards**

As practice was noted to be variable across Wales, all areas should review whether appropriate training in restraint/safe holding specific for use with older people is in place and ensure that all staff are appropriately trained.

All areas need to review staff understanding and use of legal safeguards including the need to use care and treatment planning documentation as required under the Mental Health (Wales) Measure 2010, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards and the Mental Health Act 1983 and other guidance for use with vulnerable adults.

### **Daily activities**

It is important to ensure that patients can access daily activities which are enjoyable, meaningful and which can provide a distraction. While some patients may be able to enjoy structured activities, others may only be able to engage with simpler 'failure free' activities. It is of benefit to both patients and staff caring for them that a range of activities is available on every ward. As observed in some areas, spending hours with nothing to do is not acceptable and can cause further harm to the patient.

All areas should ensure meaningful activities are in place seven days a week working with support from occupational therapists and also the wider community. Visits by hospital chaplains, hairdressers, local school choirs, volunteers such as those working with Age Cymru and others are known to benefit the patients and these were usual in the more innovative wards.

### **Relatives or carers and their involvement in the care of the patient**

Relatives and carers should be valued by services. They provide an irreplaceable source of information as well as support and care for the patient. Services can draw on them to understand how their provision for the individual and more widely can improve. They must be consulted about a range of decisions, for example covert medication usage and end of life decisions in line with existing guidance and legal requirements.

Flexible visiting hours should be encouraged.

The development of relative and carer groups is valuable for patients, staff and the relatives themselves.

It is recommended that staff must work together with patients and families to develop care plans, a form of engagement that is known as "co-production".

### **Culture and leadership**

The culture of mental health inpatient services for older people needs to be person-centred and holistic with a positive culture of care. The review team observed good staff morale and good care in wards where the culture of care was positive, services were designed around people, and clinical care was influenced by the views of relatives and carers.

Staff need clear guidance for action where they need to raise concerns about issues that they may consider to be outside their control. Even if policies are already in place, awareness raising should be undertaken, including highlighting of the safeguards and support contained within the policies.

A strong multidisciplinary team with a stable group of doctors, nurses, occupational therapists, pharmacists, psychologists and other allied health professionals, working together with clear lines of accountability and a defined management structure is most likely to result in good care being provided. This was not always present. All staff even where they are already doing their best for patients, need to be supported to be able to achieve higher standards of care. This will help staff understand better what good looks like as well as share good practice. The establishment of an older people's mental health "community of practice" is underway with support from the Welsh Government to start to achieve this.

### **Additional areas for learning**

It is vital that an active estates strategy is in place ensuring that there are timely and appropriate responses to requests for routine maintenance such as toilet repair and removal of broken or no longer used items, and with standards set for responses and mechanisms for investigation of breaches.

### **GOOD PRACTICE**

Examples of good practice for each hospital site can be found in the individual hospital reports.

### **ACKNOWLEDGEMENTS**

The Welsh Government and the Ministerial Spot Check Team would like to extend their thanks to all patients, relatives and carers and staff across the NHS organisations who participated in the spot check visits and advice from HIW reviewers. Our gratitude also extends to all individuals who contributed, without their help and assistance, the spot check process would not have been achieved.

#### Overseeing the Process

Professor June Andrews FRCN – joint author, *Trusted to Care*

Mark Butler – joint author, *Trusted to Care*

Professor Phillip Routledge OBE – project oversight, *Trusted to Care* and All Wales Medicines Strategy Group

Donna Ockenden – Independent Healthcare Advisor and Author of the External Review into Tawel Fan ward

Kim Williams – Consultant Psychologist, Cwm Taf UHB

#### Managing the Process

The spot check programme was directed by the Welsh Government's Mental Health and Vulnerable Groups team working closely with the Office of the Chief Nursing Officer.

## **APPENDIX 1**

### **Review Team**

#### **Review Team Leaders**

##### Denise Richards

Denise has 37 years experience as a Registered General Nurse. She has held many clinical and managerial positions during her career. In September 2013 she retired from the post of Nursing Officer for Patient Experience & Acute Services for the Welsh Government. In her role as Nursing Officer she led the development and implementation of *Free to Lead, Free to Care* which included the introduction of the *All Wales Nutritional Care Pathway, All Wales Food and Drink Chart, Fundamentals of Care Audit Tool* and the *Nursing Dashboard*. Denise remains committed to improving the patient/user experience and since retirement has worked closely with HIW developing the *Dignity and Essential Care Inspection Tools*.

##### Martin Semple

Following qualification as a Registered General Nurse in 1983, Martin undertook a number of roles in acute medicine and rehabilitation settings. In 1990 he had begun work as a nurse tutor in a school of nursing. During this time he conducted research on the impact of clinical placement on student nurses' attitudes to the care of the elderly person.

In 1995 he became senior lecturer in nursing at the University of Glamorgan. In 2002 Martin moved to work as the Senior Lifelong Learning Fellow at the Royal College of Nursing where he helped to set up the online learning facility known as the Learning Zone.

In 2004, Martin was appointed Head of the Royal College of Nursing Institute in Wales where he was responsible for the development and delivery of programmes of learning for RCN members in Wales. In 2008 Martin was appointed Associate Director (Professional Practice) at RCN Wales. In 2014 Martin became Nursing Officer (Patient Experience) at the Welsh Government.

##### Jenifer French

Jenifer French, formerly Nursing Officer for Mental Health and Learning Disabilities, Office of the Chief Nursing Officer, Welsh Government at the time of the visits. Jenifer is now Divisional Lead Nurse for Mental Health and Learning Disabilities at Aneurin Bevan UHB.

##### Judith White

Judith worked in the NHS for over 38 years as a Registered General Nurse, midwife and senior healthcare professional. Judith has developed extensive knowledge and expertise in the field of patient safety and clinical risk management and has experience of undertaking complex patient safety investigations. Judith has successfully managed and developed teams, established and/or implemented policies, procedures and processes within individual health organisations and on an all-Wales basis. Judith retired in 2012 and since then she has undertaken work both in the NHS and as an independent patient safety investigator and reviewer. Judith is also a reviewer for HIW.

## Senior Older People's Mental Health Nurses

### Lorraine Edmunds

Lorraine, **Registered Mental Nurse** qualified in 1986 and has breadth of operational and professional leadership experience gathered from roles spanning 32 years as a registered mental health nurse. She has held senior nursing and clinical roles across adult and older adult mental health, in NHS Wales, the private sector, South Australia and a national mental health lead role in NHS Direct Wales. Lorraine has developed many policies and procedures for mental health nursing practice. Lorraine has a sincere passion for addressing mental health stigma and disadvantage and developing integrated practice to improve clinical services and patient and carer experience and developing the practical application of concepts of person centered care. Lorraine has significantly influenced the improvements in dementia services in ABUHB, introducing service redesign such as integrated memory services and leading projects such as the RAID pilot.

Lorraine holds a BSc Honours Degree in Mental Health Nursing, post basic specialist qualifications in Counselling, Community Health Studies and an MSc in Integrated Care Management.

### Suzanne Leonard

Since qualifying as a **Registered Mental Nurse** in 1984 Suzanne has had a varied and interesting career and held many clinical and managerial positions. Suzanne has extensive skills and knowledge with experiences in community and inpatient positions across nursing specialities within mental health. Throughout her career, she has successfully developed and managed teams, within several health organizations. In her current role as Community/Liaison Nurse Manager, she provides professional leadership, clinical advice and support to the nursing workforce within mental health older peoples services. Suzanne has experience in undertaking reviews of inpatient care and writing reports that reflect current practice with recommendations to improve patient care and experience. She is also a trained RCA investigation officer and has experience in conducting investigations.

### Donna Pritchard

Donna has 33 years experience working as a Registered Mental Nurse in Mental Health services. The latter 20 years has been focused in Older Adults Mental Health. Her experience has covered many aspects of management and care including managing inpatient units, operational management of the process for Continuing NHS Health Care for Ceredigion LHB, a three-year secondment working with Ceredigion Social Services managing Mental Health and Learning Disability services, and more recently managing Older Adult Mental Health Services across Hywel Dda UHB. She has experience in the development of policies and procedures as well as managing service change.

### Sara Rees

Sara has worked within the NHS for 33 years, she started her career as an Enrolled Nurse converting to RMN Registered Mental Nurse in 1987. Whilst having worked in most specialties within mental health Sara chose to commit to working within Older Persons Mental Health. Her breadth of experience encompasses inpatient care, day units, community and memory clinics, both in England and Wales. Sara's experience has provided her with an understanding of the patient journey through the mental health services and the challenges that this presents to both patients and their loved ones. As a Senior Nurse, Sara is able to use that experience to ensure that the patient journey remains central to the care provided and development within the service.

## **Older People's Pharmacists**

### **Tim Banner**

Tim studied pharmacy in De Montfort University, Leicester, graduating in 2003. He initially worked in Singleton Hospital, Swansea gaining experience of numerous hospital pharmacy areas before specialising as an Elderly Care pharmacist. Tim then moved to Hywel Dda University Health Board (formerly Carmarthenshire LHB) as a prescribing advisor, this time allowed Tim to qualify as an independent prescriber and set up a clinic to reduce prescribing of Hypnotics and Anxiolytics. The position also gave Tim the opportunity to develop his leadership and managerial skills. In 2014 Tim was appointed as a Consultant Pharmacist Care of Older People (Cardiff and Vale UHB) and Community Healthcare (All Wales), this new challenging post gives Tim the opportunity to support the care of vulnerable older people with complex needs (including care homes), develop and share pharmaceutical best practice across Wales in the areas of domiciliary and community care, long term care and social care and provide leadership on issues relating to the practice of continuing care pharmacy services across Wales. Tim is now Consultant Pharmacist Care of Older People and Community Healthcare (All Wales).

### **Jayne Price**

Jayne is currently a Senior Pharmacist with Powys Health Board and has over 18 years experience in the NHS. After qualifying Jayne worked at Hereford where she gained experience in all aspects of hospital pharmacy, including being Clinical Pharmacist for the acute admissions, age care and general medical wards. Jayne progressed to Lead Pharmacist for Medicines Information and became a member of the Senior Pharmacy management team. Jayne moved to Powys in 2008. She wrote the Medicines Policy for Powys and advised on the specification for the storage of medicines for both a new Health and Social Care Unit and a Stroke Unit.

Throughout her career Jayne has played a key role in training healthcare professionals in aspects of medicines management. She helped to develop and now delivers an accredited training package, to enable Domiciliary Care workers to safely administer medicines in patients' homes.

### **Suzanne Robinson**

Suzanne is currently Lead Clinical Pharmacist for Mental Health in Cwm Taf UHB and has 25 years experience in Mental Health. Suzanne has during her pharmacy career covered most specialities within a district general hospital including Intensive Care, SCBU and provided Medicines Information services. After qualifying in 1987 Suzanne completed a postgraduate Certificate and Diploma in Psychiatric Pharmacy and subsequently registered as a Supplementary and then Independent Prescriber within the Mental Health Directorate. Suzanne is involved in training pharmacy professionals in-house and as part of the Postgraduate Diploma in Cardiff and medical students during their 4<sup>th</sup> year Mental Health rotation placement.

## **Older People's Occupational Therapists**

### **Fiona Crook**

Fiona qualified as an Occupational Therapist in 1989. After gaining a range of clinical experience she specialised in the field of Older Persons Mental Health where she has 20 years experience working with individuals with a diagnosis of dementia and functional

illnesses. Fiona is currently working as a Clinical Specialist Occupational Therapist in Cwm Taf UHB.

Fiona has led a team of Occupational Therapists working in Older Persons Mental Health and has been instrumental in service change and development. This has included the introduction of the Pool Activity Level Assessment Tool, recommended by NICE Guidelines for “activity of daily living training and activity planning”. This is now widely used as it increases person centred care and activity engagement.

During her career Fiona has delivered presentations and training sessions to a range of health professionals and carers including *The importance of purposeful and meaningful occupations* and *How to manage challenging behaviours and the impact the environment has on dementia patients*.

### Rebecca Hanmer

Rebecca is currently is the Lead Occupational Therapist of Older Persons Mental Health Services, Abertawe Bro Morgannwg University Health Board. Rebecca has more than 18 years experience of working and understanding care environments, in different roles and at different levels. Rebecca’s working experience covers Welsh, English and Australian health care systems. Rebecca’s largest part of her experience as an Occupational Therapist has been within mental health settings, particularly those for older people. She has been privileged to work also within physical health and social care settings intermediate care, intensive care, and forensics.

Within her current role as a clinical leader she has developed pathways and protocols to support and ensure effective service delivery for older people with mental health difficulties; introduced the use of the Cognitive Disability Model across OT areas in ABMU, and within third sector providers; assisted the supervision of occupational therapists in her own and other organisations to integrate the Cognitive Disabilities Theories into practice; actively participated in formal initiatives and informal networks to support dementia care across organisations; supported with the creation of guidelines for the Health Board to support the recognition, prevention and management of delirium and the appropriate use of antipsychotics in patients with dementia and cognitive impairment; devised and developed the accredited AGORED Cognitive Impairment Unit qualification for therapy support workers across Wales; been involved in the design and planning of the dementia care wards Ysbryd Y Coed, 60 bed inpatient Unit, Cefn Coed Hospital, which achieved the Construction Excellence Award in Wales.

Rebecca is a member of the Mental Health Wales Occupational Therapy Network, National Speciality Advisory Group (NSAG) for Older People and British Association of Occupational Therapy.

### Kelly Rice

Kelly has worked for Hywel Dda University Health Board since 2001, starting out as an Occupational Therapist Technician at Y Delyn Day Hospital in Carmarthen which accommodated up to fifteen clients daily with Dementia and functional illnesses.

Kelly completed the four year All Wales Occupational Therapy in Service Training degree at Cardiff in 2007 gaining a BSc (Hons) in Occupational Therapy. On qualification Kelly worked as a Basic Grade Occupational Therapist on Morlais ward, an Older Adult Mental Health assessment unit in Carmarthen. In 2008 she became the Occupational Therapist for the Carmarthen Older Adults Community Mental Health Team and Memory Clinic; progressing to clinical Lead Occupational Therapist in 2013. Her current role involves managing a

caseload of clients with specialised complex needs, using evidence based and person - centred principles to assess, plan, implement and evaluate interventions in primary, community and secondary care settings. Kelly's role involves working with Older Adults with Dementia, including people with young onset Dementia, assessing the impact of cognitive impairment on occupational participation in everyday activities.

### **Older People's Psychiatrist**

#### Pauline Ruth

Dr Ruth commenced her first substantive Consultant post in Older Adult Mental Health Services in Gwent in 1993 becoming Lead Clinical Director for Mental Health & Learning Disability Services in 1999 and Chief of Staff in 2002. She remained Clinical Director for Older Adult Mental Health Services until April 2014 when she retired but returned to work part time as Consultant for North Monmouthshire.

Throughout her career Dr Ruth has been committed to improving services for Older Adults with a special interest in dementia. She has been actively involved in the 1000 lives programme improving services across Wales for Older People and has been influential in the modernisation and further development of inpatient and community services across Aneurin Bevan Health Board.

Over the years Dr Ruth has been educational supervisor, SpR trainer, OSCE examiner for medical students, assistant tutor, speciality tutor for Old Age Psychiatry, Honorary Lecturer and Clinical Teacher at the Department of Psychological Medicine in Cardiff, Special Study Module Tutor and the organiser of the sub speciality teaching for MSc Psychiatry in Wales. She has also been a Member of the Royal College of Psychiatrists approval team.

Dr Ruth lives with her family in Monmouthshire and has for some years been a carer for her own elderly mother who has Alzheimer's disease.