Unannounced Inspection Report – care for older people in acute hospitals

Belford Hospital and MacKinnon Memorial Hospital | NHS Highland

24-25 June 2014
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1 About this report

In June 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a new programme of inspections. These inspections are to provide assurance that the care of older people in acute hospitals is of a high standard. We will measure NHS boards against a range of standards, best practice statements and other national documents relevant to the care of older people in acute hospitals, including the Clinical Standards Board for Scotland (CSBS) Clinical Standards for Older People in Acute Care (October 2002).

Our inspections focus on the three national quality ambitions for NHSScotland, which ensure that the care provided to patients is person-centred, safe and effective. The inspections will ensure that older people are being treated with compassion, dignity and respect while they are in an acute hospital. We will also look at one or more of the following areas on each inspection:

- dementia and cognitive impairment
- falls prevention and management
- nutritional care and hydration, and
- preventing and managing pressure ulcers.

This report sets out the findings from our unannounced inspections to Belford Hospital and MacKinnon Memorial Hospital, NHS Highland from Tuesday 24 to Wednesday 25 June 2014.

This report gives a summary of our inspection findings on page 5. Detailed findings from our inspection can be found on page 5.

The inspection team to Belford Hospital was made up of three inspectors and a public partner, with support from a project officer. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. A key part of the role of the public partner is to talk to patients and listen to what is important to them. Membership of the inspection team visiting Belford Hospital and MacKinnon Memorial Hospital can be found in Appendix 2.

The report highlights areas of strength and areas for improvement. All areas for improvement from this inspection can be found in Appendix 1 on page 16. Wherever possible, the areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action. A list of relevant national standards, guidance and best practice can be found in Appendix 3.

More information about Healthcare Improvement Scotland, our inspections, methodology and inspection tools can be found at http://www.healthcareimprovementscotland.org/OPAH.aspx
2 Summary of inspection

Belford Hospital, Fort William, contains 34 inpatient beds, a 10-bedded day case unit and provides a wide range of healthcare specialties. This includes consultant-led general medical and general surgical services. The accident and emergency department is one of the busiest mountain trauma units in Europe.

We carried out an unannounced inspection to Belford Hospital on Tuesday 24 to Wednesday 25 June 2014.

We inspected the following areas:
- combined assessment unit, and
- ward 1 (acute mixed/acute rehabilitation).

MacKinnon Memorial Hospital is located in Broadford, Isle of Skye. It contains 20 inpatient beds and provides services to the Skye and Lochalsh area. The services which the hospital provides include an accident and emergency department and general medical services.

We carried out an unannounced inspection to MacKinnon Memorial Hospital on Tuesday 24 June 2014 and inspected the general ward department.

Before the inspection, we reviewed NHS Highland’s self-assessment and gathered information about Belford Hospital and MacKinnon Memorial Hospital from other sources. This included Scotland’s Patient Experience Programme, and other data that relate to the care of older people. Based on our review of this information, we focused the inspection on the care of people with dementia and cognitive impairment, nutritional care and hydration, and preventing and managing pressure ulcers. Ensuring that older people are treated with dignity and respect is a focus on all our inspections.

On the inspection, we spoke with staff and used additional tools to gather more information. In all wards, we used a formal observation tool. We carried out six periods of observation during the inspection. In each instance, members of our team observed interactions between patients and staff in a set area of the ward for 20 minutes.

We carried out patient interviews and used patient and carer questionnaires. Overall, we spoke with 11 patients; eight patients during the inspection to Belford Hospital and three patients during the inspection of MacKinnon Memorial Hospital. We also received completed questionnaires from 11 patients and two family members, carers or friends.

As part of the inspection, we reviewed 14 patient health records to check the care planned and delivered was as described in the care plans. For this inspection, we reviewed all of the patient health records for dementia and cognitive impairment, nutritional care and hydration, and preventing and managing pressure ulcers.

Areas of strength
We noted areas where NHS Highland was performing well in relation to the care provided to older people in acute hospitals.

- We received no negative comments from patients and relatives.
- There is an integrated approach to delivering care in the most suitable environment using a virtual ward in the community supported by Belford Hospital.
- In MacKinnon Memorial Hospital, the inpatient virtual ward round provides a multi-disciplinary approach to continuously reviewing patients and supporting effective discharge.
- There is good access to the kitchens, in both hospitals, outwith mealtimes.
- Protected mealtimes are adhered to which aim to reduce non-essential interruptions during mealtimes.

**Areas for improvement**

We found that further improvement is required in the following areas.

- We found a lack of information in the personalised care plans outlining the individual needs of older people. This care plan should identify the specific needs of the patient and how staff will meet these needs.
- Screening for cognitive impairment was not routinely carried out in patients over 65 years when they were admitted to hospital.
- At Belford Hospital, the ward and hospital environment must be made more suitable for people with dementia and cognitive impairment.
- We found that not all patients had their height and weight recorded as part of a full nutritional assessment within 24 hours of admission to hospital and on an ongoing basis.

**What action we expect NHS boards to take after our inspection**

This inspection resulted in five areas of strength and 11 areas for improvement. A full list of the areas for improvement can be found in Appendix 1 on page 16.

We expect NHS Highland to address all the areas for improvement. Those areas where improvement is required to meet a recognised standard must be prioritised.

Since carrying out the inspection to MacKinnon Memorial Hospital, we have been informed that it is no longer classified as an ‘acute’ hospital. The hospital will remain open as a ‘community’ hospital. While we expect NHS Highland to implement our areas for improvement, we will not undertake further older people in acute hospital inspections to MacKinnon Memorial Hospital.

The NHS board has developed an improvement action plan, which is available to view on the Healthcare Improvement Scotland website [http://www.healthcareimprovementscotland.org/OPAH.aspx](http://www.healthcareimprovementscotland.org/OPAH.aspx)

We would like to thank NHS Highland and in particular all staff at Belford Hospital and MacKinnon Memorial Hospital for their assistance during the inspection.
3 Our findings

Treating older people with compassion, dignity and respect

During the inspection to Belford Hospital and MacKinnon Memorial, all wards we observed appeared calm and organised.

At Belford Hospital, all patients were in single sex bays or single rooms. Toilet and shower facilities were not en-suite and were shared. This is due to the age and design of the building. However, patients were placed to ensure that the toilets were being used by one gender only.

At MacKinnon Memorial Hospital, many of the rooms and areas are multifunctional due to space limitations. However, we found that ward areas were not cluttered.

All patients had easy access to the nurse call buzzers and fluids. The wards appeared calm and we saw that nurse call buzzers were answered promptly. We observed staff addressing patients by their preferred name and engaging in friendly, polite conversations. Patients were dressed appropriately with personal items such as hearing aids and glasses being used. Information on display above the patient’s bed was risk-based and provided a prompt for staff, for example information on mobility or nutritional needs.

Virtual wards

Two years ago, Belford Hospital introduced an integrated system using ‘virtual wards’. The virtual ward is a multidisciplinary approach to ensuring patients are maintained in an environment that is familiar to them. This brings together GP practices, community staff and social work. The consultant geriatrician from Belford Hospital will also carry out home visits, if necessary. It links health and social care to co-ordinate care and discuss issues, such as compliance with taking medications or refusing care.

Patient comments

Through our patient surveys and interviews, patients had the opportunity to give us their opinion of the care they received. Overall, patients were positive about the care and the assistance they had received from all members of staff. Of the 11 patients who completed our questionnaire:

- 100% said that the quality of care was good, and
- 90% said they have been given clear information about their condition and treatment.

We received the following positive comments from patients through the patient surveys:

- ‘Staff [are] always friendly and helpful. Meals excellent, care second to none.’
- ‘Absolutely great hospital, brilliant staff, food first class.’

During the inspection to both hospitals, we spoke with 11 patients. They told us:

- ‘I have constant care.’
- ‘The doctors listen to you when discussing treatment/care and ask how I am feeling.’
- ‘Discharge planning was discussed today between my wife and home help on what needs to be done to get me home.’
• ‘Staff are perfect and make you feel at ease.’
• ‘Staff are considerate and make sure I am comfortable.’
• ‘If the ward is full, staff speak quietly when discussing my treatment.’

Patient and staff interactions
We used a formal observation tool in all of the wards inspected to observe interactions between staff and patients. We observed positive and caring interactions with patients. We found that staff were encouraging and supportive, and talked to patients in a respectful manner. We observed nursing staff introducing themselves to patients, asking patients how their night had been and explaining what the plan of treatment was for the day. For example, we observed a staff nurse telling a patient their bloods were going to be taken today and that they would be going for an X-ray later that morning.

Documentation
At Belford Hospital, active care rounding is in place within the wards inspected. This is when staff check on individual patients at defined regular intervals to anticipate any care needs they may have for example, pain relief or needing the toilet. Although documentation was consistently completed within the stated time frequency, it was unclear how the frequency was informed by assessments.

At MacKinnon Memorial Hospital, although active care rounding was not in place, we found that staff knew the patients’ needs, they were visible in patient areas and care was observed to be person centred. Staff at MacKinnon Memorial Hospital use the hospital’s own version of an inpatient admission booklet. The MacKinnon Memorial Hospital inpatient admission booklet includes pages for writing individual care plans. However, there was an inconsistent approach to the completion of this documentation. The hospital is awaiting the new NHS Highland admissions booklet, which will be used across the NHS board.

Documentation at both hospitals was not consistently completed. Some documentation was not legible and had not been dated or signed. Assessments of ability to perform key daily activities of living, for example mobility, washing and dressing, and eating and drinking were not always fully completed. Therefore, it was unclear what the patients’ needs were. Where care plans were being used, they were not always person centered and did not provide sufficient detail to guide care.

In accordance with Chief Medical Officer (CMO) (2013)18, when a patient is admitted to hospital for more than 24 hours, medicines reconciliation should take place. This should include a documented record of patient’s details and whether they have any allergies. Any medicines prescribed to the patient should only be listed after checking with two or more sources. This can be the patient, a carer, GP, pharmacy or a printed GP letter. There should also be a medicines plan for each medicine to indicate if to ‘continue’, ‘stop’ or ‘withhold’. It should be clear who has completed the form and there should also be evidence of a pharmacist review.

During our inspection to Belford Hospital, we looked at nine patient health records for medicines reconciliation. Of these, four were completed fully and two were partially completed. The patient’s allergy status was not documented in four of the records with some records having no medicines plan or signature completed. This may result in the patient not receiving the correct prescribed drugs during their stay in hospital or changes not being communicated to the patient and GP on discharge.
Discharge planning

At Belford Hospital, we were told that each patient is reviewed for discharge at the weekly multidisciplinary team meeting and during daily board rounds. However, we found that no estimated dates of discharge were documented. We were told that six patients had their discharge delayed due to requiring services or alternative care. There was evidence of multidisciplinary team working to ensure that patients could receive the appropriate care and treatment to meet their medical, functional and social needs.

At MacKinnon Memorial Hospital, the senior charge nurse told us about the ‘inpatient virtual ward round’ which is a multidisciplinary approach to the care of patients. A daily conference call takes place between hospital staff, a physiotherapist, occupational therapy, the homecare manager, social work and district nursing staff. If there is a patient who has more complex needs, then a face to face meeting is arranged. This supports a good co-ordinated approach to planning the discharge of patients from hospital.

Discharge checklists were in place in all of the patient health records we reviewed. We were told that these are completed on the day of discharge. However, this does not evidence the discharge planning process throughout the patient’s stay. Discharge planning should be a continuous process from admission, which includes documentation.

Areas of strength

- We received no negative comments from patients or relatives through our interviews and patient and carer surveys.
- There is an integrated approach to delivering care in the most suitable environment using a virtual ward in the community supported by Belford Hospital.
- The inpatient virtual ward round in MacKinnon Memorial Hospital provides a multidisciplinary approach to continuously reviewing patients and supporting effective discharge.

Areas for improvement

1. NHS Highland should ensure the consistency of documentation across all acute hospital sites.
2. NHS Highland must ensure that all documentation, both nursing and medical, is legible, dated, timed and signed. It should provide details of any assessments and reviews undertaken, and provide clear evidence of the arrangements that have made for future and ongoing care. It should also include details of information given about care and treatment.
3. NHS Highland must ensure that documentation supports effective discharge planning and is a continual process throughout the patients stay in hospital.

Dementia and cognitive impairment

Screening and assessment of people with dementia and cognitive impairment

NHS Highland’s self-assessment states that patients with cognitive impairment have an initial assessment carried out in the accident and emergency (A&E) department using the 4AT screening tool in Belford Hospital. In MacKinnon Memorial Hospital, this is undertaken within 24 hours of admission to the ward. A full medical assessment is carried out at both sites within 2 hours of admission. This is noted in the medical notes.
At Belford Hospital, out of the 14 patient health records reviewed, 10 patients were screened and assessed for dementia and cognitive impairment by nursing staff using the 4AT tool. This is also used as a screening tool for delirium. We saw that one patient had refused to be screened on admission. This was documented in the patient notes and staff were going to try again the next day. Another patient had the assessment partially completed.

It was difficult to establish when assessments had been carried out as there was no place to record the date and time. Ward staff did not know whether to use a single 4AT sheet or use the 4AT on the national early warning score (NEWS) chart. There was no guidance for staff on repeating the 4AT or where to record it again after the initial assessment.

We were told in the pre-assessment unit for surgical patients, there is no routine assessment of cognition, or capacity to consent to treatment, unless concerns have been raised or there is an identified issue. When cognitive assessments and screening showed a possible impairment, there was no evidence that further action had been taken as the 4AT score was not recorded in the patient’s medical notes. This may result in a patient not being referred to an appropriate person for further investigation or receiving a diagnosis to guide future treatments and decision-making. There were no identified pathways to guide staff when a cognitive impairment was identified.

We reviewed a patient health record which stated the patient had dementia. It was noted that the patient was, at times, stressed and distressed. Although we saw positive interactions between staff and the patient, we were concerned about the care that the patient was receiving. We found that there was no care plan in place to guide staff on how to care for the patient or how to manage the patient’s stress and distress. Staff were also putting medication into the patient’s food as they were refusing to take the medication prescribed. This is known as ‘covert medication’. The decision to give medication in this way has to be on an individual basis, with a risk assessment carried out and the rationale for this decision taken.

However, we did not find this process had been followed. In addition, when asked, ward staff were not aware of NHS Highland’s covert medication policy. We also found in the same patient health records that the patient had no bowel movement for 10 days and this was not picked up by staff. This highlighted that information was not always handed over between shifts to inform patient care.

Due to our concerns, we asked for a review of the patients’ care. NHS Highland provided us with a revised staff handover procedure issued to all staff on 24 June 2014. This should ensure that all key information and up to date assessments are communicated between shifts to ensure that the patients’ needs are met. We are assured that the patient’s care had been reviewed and that staff were made aware of the NHS Highland covert medication policy.

At MacKinnon Memorial Hospital, we found in one patient health record that, on admission, the patient was noted to be ‘confused’ and ‘disorientated’. We found that this did not prompt staff to complete the 4AT screening tool. The patient was screened the following day and showed a possible impairment. The patient was then rescreened the following day. This was not recorded in the patient’s medical notes. There was no patient pathway for staff to follow. There was no plan of care and nothing documented about whether this patient was still confused or if this had resolved.

Care planning for people with dementia and cognitive impairment

At Belford Hospital, two patients were known to have dementia before admission to hospital. There was no evidence of assessments being carried out to identify specific needs of the patients or care plans to guide how the care would be delivered. For example, if the person...
requires prompting or actual assistance with washing and dressing, eating and drinking or how to manage distressed behaviour.

At MacKinnon Memorial Hospital, three patients were recorded as being ‘confused’. There was no plan to guide their care or treatment in the patient health records.

**Adults with incapacity**

The adults with incapacity (AWI) form is used to authorise treatment for patients who are unable to consent themselves. When people who have lost the capacity to make decisions about their welfare are admitted to hospital, it is important to know if they have an appointed power of attorney or guardian. This is someone who is appointed to make decisions on another person’s behalf when they are unable to do so themselves.

During the inspection, we saw three AWI certificates with accompanying treatment plans. However, there was no record of an assessment of the patient’s capacity to consent to treatment in the patient medical record. One record gave the reason for the AWI as being that the patient had an AWI certificate in place in the community. The other was written three and a half months after the patient’s admission to hospital despite there being issues with the patient’s behaviour and concern about their mental state. This does not reflect that an assessment of the patient’s capacity to consent to treatment whilst in hospital had been considered. NHS Highland should continue to improve the assessment of capacity for patients requiring an AWI certificate and the associated documentation. We are not making an area for improvement within the report at this time due to only viewing three certificates during the inspection.

**Environment for people with dementia and cognitive impairment**

People with dementia or cognitive impairments can benefit from environments that are adapted to limit potential confusion and distress.

At Belford Hospital, we found that dementia-friendly signage was poor. Although the wards had some pictorial signage depicting toilets on the outside of the toilet doors, there was no use of contrasting colours and the ward flooring reflected the light. There was also no evidence of individual identity markers outside the single rooms to aid way finding. It may be difficult for patients and visitors to find their way from the front entrance to many of the wards as the signage print was small. There were also no signs on front of the lift doors to inform patients or visitors of the floor number or which wards were on each floor.

At MacKinnon Memorial Hospital, we found yellow pictorial signage depicting toilets on the outside of the toilet doors. NHS Highland has introduced a contrast colour on toilet seats so that patients with dementia can distinguish the toilet seat from their surroundings.

**Dementia champion**

During the inspection, we spoke with the dementia champion in Belford Hospital. Their role is to provide resources for the combined assessment unit and to support staff to develop skills and knowledge for dementia care. However, they do find it difficult to support other areas of the hospital due to time constraints of their own role. They told us that, if required they can access the Alzheimer’s nurse consultant.

**Areas for improvement**

4. NHS Highland must ensure that all older people who are being treated in accident and emergency, or are admitted to hospital, are assessed and screened for cognitive impairment.
5. NHS Highland must ensure that patients identified as having cognitive impairment have a personalised care plan in place. This should identify the specific needs of the patient and how the staff will meet these needs.

6. NHS Highland should ensure that improvements to the ward and hospital environment at Belford Hospital are carried out to make it more suitable for people with dementia and cognitive impairment.

Nutritional care and hydration

Nutritional assessment and personalised care plans

NHS Highland’s self-assessment states that various risk assessments are carried out when patients are admitted to Belford Hospital and MacKinnon Memorial Hospital, including the Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. An appropriate care plan should be produced for each patient once the risk category has been established. The MUST includes information on:

- a patient’s height and weight
- the patient’s body mass index (BMI)
- any unplanned weight loss, and
- whether the patient is acutely ill and has not eaten for more than 5 days.

During the inspection, we reviewed 14 patient health records for nutritional care. We found that eight MUSTs had been completed within 24 hours of admission. It was not stated how the majority of the patients’ height and weights recorded were obtained (such as measured, estimated or reported). Weighing scales were available for use when patients were not able to get out of bed and a measure for height was also available.

BMI is a measure of relative weight based on an individual's mass and height.

At Belford Hospital, BMIs were not always accurately calculated. For example, one patient was recorded as 26 when the correct score was 28. Another was recorded as 18.5 when the correct BMI was 26.8. Although in these cases it did not impact on the MUST score, it could have an impact on other assessments such as pressure ulcer risk.

There was limited evidence of rescreening being carried out within the hospital. This can result in patients, who are at risk of malnutrition, not being identified and having appropriate interventions and care put in place. For example, one patient was not screened until 11 days after admission. They were then weighed but no overall MUST score was calculated. The patient was rescreened after 9 days, although patients should be rescreened weekly. The weight of the patient showed an unplanned weight loss of 6.7kg (5-10%). This indicates that the patient was at medium risk of malnutrition. This should have prompted the appropriate interventions, such as starting a food chart. The patient was rescreened 6 days later and the weight was recorded as showing a continued unplanned weight loss of 0.9kg. There was nothing documented in the patient notes, or the care plan, to reflect the changes in the patient’s condition or actions taken. This was brought to the attention of the senior charge nurse and the hospital management. We were assured that the patient’s care had been reviewed.

At MacKinnon Memorial Hospital, the inpatient admission booklet includes a care plan section for eating and drinking. However, we found that these were not consistently

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completed. One patient did have personalised diet information recorded. However, another patient who was ‘nil by mouth’, and had a nasogastric feeding tube inserted, did not have these details recorded.

There was also limited information to guide staff on how to meet the identified needs of patients with nutritional requirements. Nutritional profiles which detail ‘likes and dislikes’, special dietary requirements or personal needs, were not fully completed and did not always contain correct information. For example, one stated that the patient required a special diet for a medical condition, but it was not highlighted that the patient also had another special dietary requirement. Where care plans were in use they were generic, with very little person-specific interventions and did not provide sufficient detail to guide care.

**Protected mealtimes and provision of snacks**

At Belford Hospital, we observed two separate mealtimes, breakfast and lunch. All wards had protected mealtimes in place and these were seen to be adhered to. Mealtime co-ordinators ensured that all meals were served, in a timely manner, to the correct patients. We also saw that assistance was given to patients, with staff allowing time for the patient to eat their meal. There was also a choice of drinks served with the meals. Staff were able to state how to obtain meals for patients who were out of the ward at mealtimes. Each area had a choice of snacks available and had access to the main kitchen out with hours to make sandwiches and obtain yogurts and ice-cream.

At MacKinnon Memorial Hospital, we observed a domestic washing the floor of a patient room during a mealtime. However, the member of staff stopped when advised meals were being served. A member of the catering staff gave the meal trays from the trolley to ward staff who then served the meal trays to patients. We observed assistance given in a timely manner with staff allowing time for the patient to eat their meal. We observed a nurse going to the kitchen to get a patient their dessert which was missing from their meal tray. However, we did not observe patients being given a choice of drink with their meal.

All patients found the food to be appetising, hot and of adequate portions. At Belford Hospital, a patient told us that a special meal was prepared for them as they are diabetic. The patient found this meal appetising.

Both hospitals have an on-site kitchen with staff available until 7pm every day. There is also a tea tray with hot drinks and snacks for patients in the evening. Staff are able to get food and snacks from the kitchen. Patients told us that snacks, for example, sandwiches were available as an alternative or when patients arrived after meals had been served. One patient arriving late from accident and emergency was offered a hot meal, a snack and drinks.

At MacKinnon Memorial Hospital, ward staff liaise with kitchen staff during a daily ‘catering brief’ to update the kitchen on which patients are being discharged in an effort to reduce food wastage. This is good practice.

**Areas of strength**

- Protected mealtimes are adhered to which aim to reduce non-essential interruptions during mealtimes.
- There is good access to the kitchens, in both hospitals, outwith mealtimes.
Areas for improvement

7. NHS Highland must ensure that all patients have their height and weight recorded, and are accurately screened for the risk of under nutrition, as part of a full nutritional assessment within 24 hours of admission to hospital and on an ongoing basis.

8. NHS Highland must ensure personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients.

Preventing and managing pressure ulcers

NHS Highland uses the Waterlow risk assessment tool to assess a patient’s risk of developing a pressure ulcer. National guidance states that this assessment should be completed within 6 hours of admission. A skin care bundle, SSKIN (skin, surface, keep moving, incontinence, nutrition), is also used to prompt staff to check the patient’s skin integrity.

During the inspection, we reviewed 14 patient healthcare records for pressure area care. We found that nine Waterlow risk assessments had been completed within the timescale.

At Belford Hospital, all patients had a Waterlow risk assessment completed. However, the time when the waterlow risk assessment was undertaken was not recorded. Therefore, we could not be assured that this was completed within 6 hours of admission. We found that the majority of Waterlow risk assessments also had incorrect scores recorded due to:

- no score or incorrect score for BMI entered
- continence element not completed
- nutritional element not completed, and
- age/gender element not completed.

At Belford Hospital, SSKIN bundles were in use and completed appropriately. However, there was no documentation to support or advise the frequency for checking the SSKIN bundle was, for example every 4 hours or 6 hours. Where a risk was identified, care plans were in use, but these were not person-centered, and it was not clear what interventions were in place. For example, what type of mattress was being used or the frequency of position changes. There was no date or time recorded on all of the patient health records when the initial Waterlow assessment was completed. We found that one patient did not have a Waterlow risk assessment completed until 2 days after admission.

There was evidence of patients being reassessed. However, staff were unclear as to how often the Waterlow risk assessments were meant to be completed.

We were told that patients will only have a SSKIN bundle if their Waterlow risk assessment score is over 15. In one of the patients' notes we reviewed, a SSKIN bundle should have been completed for the patient as their Waterlow risk assessment score was over 15. However, it was not clear if the SSKIN bundle had been completed as there were pages missing from the patient’s health record.
We found no care plans for pressure area care and there was no section for pressure area within the care plan section of the MacKinnon Memorial Hospital inpatient admissions booklet. It was not clear what interventions were in place. For example, what type of mattress was being used or the frequency of position changes.

**Specialist pressure relieving equipment**

At Belford Hospital, staff stated that there was no guidance for mattress selection relating to the level of risk, and that mattress selection would be clinical judgement and experience.

At MacKinnon Memorial Hospital, there are airwave mattresses and pressure relieving cushions available. The hospital also has access to the equipment for the community. There is a tissue viability link nurse at the hospital who communicates regularly with the tissue viability nurse specialist who is based in Raigmore Hospital, Inverness.

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Appendix 1 – Areas for improvement

Areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action. The list of national standards, guidance and best practice can be found in Appendix 3.

Treating older people with compassion, dignity and respect

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Dementia and cognitive impairment

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<td>cognitive impairment (see page 11).</td>
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<tr>
<td>This is to comply with Clinical Standards for Older People in Acute Care,</td>
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<tr>
<td>Standard 2.</td>
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<tr>
<td>5 must ensure that patients identified as having cognitive impairment have</td>
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<td>a personalised care plan in place. This should identify the specific needs</td>
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<tr>
<td>of the patient and how the staff will meet these needs (see page 12).</td>
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<td>This is to comply with Standards of Care for Dementia in Scotland, page 15.</td>
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<tr>
<td>6 should ensure that improvements to the ward and hospital environment at</td>
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<tr>
<td>Belford Hospital are carried out to make it more suitable for people with</td>
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<td>dementia and cognitive impairment (see page 12).</td>
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**Nutritional care and hydration**

**NHS Highland:**

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| **7** | must ensure that all patients have their height and weight recorded, and are accurately screened for the risk of under nutrition, as part of a full nutritional assessment within 24 hours of admission to hospital and on an ongoing basis (see page 14).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.1. |
| **8** | must ensure personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients (see page 14).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.7. |

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**Preventing and managing pressure ulcers**

**NHS Highland:**

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<td><strong>9</strong></td>
<td>should ensure that the documentation provided to staff allows for the accurate recording of assessment and evaluation of pressure areas (see page 15).</td>
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</table>
| **10** | must ensure that care planning documentation is improved to provide a clear record of the care required and given to a patient and to show evaluation of that care. This documentation should also demonstrate person-centred and personalised care to meet the needs of individual patients dependent on each patient’s level of risk of developing a pressure ulcer (see page 15).

This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 4. |
| **11** | should ensure that staff have guidance on mattress selection for pressure ulcers (see page 15). |
Appendix 2 – Details of inspection

The inspection to Belford Hospital, NHS Highland was conducted from Tuesday 24 June to Wednesday 25 June 2014.

The inspection team consisted of the following members:

Ian Smith
Senior Inspector

Kenny Crosbie
Inspector

Irene Robertson
Inspector

Marguerite Robertson
Public Partner

Observed by:

Aidan McCrory
Inspector

The inspection to MacKinnon Memorial Hospital, NHS Highland was conducted on Tuesday 24 June 2014.

Claire Blackwood
Inspector

Supported by:

Nicola Grant
Project Officer
Appendix 3 – List of national guidance

The following national standards, guidance and best practice are relevant to the inspection of the care provided to older people in acute care.

- **Best Practice Statement for Prevention and Management of Pressure Ulcers** (NHS Quality Improvement Scotland, March 2009)
- **Clinical Standards for Food, Fluid and Nutritional Care in Hospitals** (NHS Quality Improvement Scotland, September 2003)
- **Clinical Standards for Older People in Acute Care** (Clinical Standards Board for Scotland, October 2002)
- **Dementia: decisions for dignity** (Mental Welfare Commission, March 2011)
- **National Standards for Clinical Governance and Risk Management** (NHS Quality Improvement Scotland, October 2005)
- **Scottish Intercollegiate Guideline Network (SIGN) Guideline 86 – Management of Patients with Dementia** (SIGN, February 2006)
- **SIGN Guideline 111 – Management of Hip Fracture in Older People** (SIGN, June 2009)
- **Standards of Care for Dementia in Scotland** (Scottish Government, June 2011)
Appendix 4 – Inspection process flow chart

This process is the same for both announced and unannounced inspections.
## Appendix 5 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AWI</td>
<td>adults with incapacity</td>
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<tr>
<td>BMI</td>
<td>body mass index</td>
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<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
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<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
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<tr>
<td>HDL</td>
<td>Health Department Letter</td>
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<td>NEWS</td>
<td>National early warning score</td>
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<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<tr>
<td>SSKIN</td>
<td>skin, surface, keep moving, incontinence, nutrition</td>
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</table>
How to contact us

You can contact us by letter, telephone or email to:

- find out more about our inspections, and
- raise any concerns you have about care for older people in an acute hospital or NHS board.

**Edinburgh Office** | Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB

**Telephone** 0131 623 4300  
**Email** [hcis.chiefinspector@nhs.net](mailto:hcis.chiefinspector@nhs.net)

[www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network (SIGN) are part of our organisation.