

Announced Inspection Report – care for older people in acute hospitals

Glasgow Royal Infirmary | NHS Greater Glasgow and Clyde

2–4 May 2012

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Healthcare Improvement Scotland Announced Inspection Report (Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde):
2-4 May 2012

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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 announced inspection to Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde from Wednesday 2 May to Friday 4 May 2012.

This report gives a summary of our inspection findings on page 5. Detailed findings from our inspection can be found on page 7.

The inspection team was made up of four inspectors and two public partners, 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 partners is to talk to patients and listen to what is important to them. Membership of the inspection team visiting **Glasgow Royal Infirmary** can be found in Appendix 2.

The report highlights areas of strength, areas for improvement and areas for continuing improvement. All areas for improvement from this inspection can be found in Appendix 1 on page 15. 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/HEI.aspx>.

2 Summary of inspection

Glasgow Royal Infirmary is a large teaching hospital in the east of the city. It has 978 inpatient beds and provides a wide range of services including an accident and emergency department and medicine for the elderly.

We carried out an announced inspection to Glasgow Royal Infirmary from Wednesday 2 May to Friday 4 May 2012.

We inspected the following areas:

- ward 17/31 (stroke)
- ward 20/21 (medicine for the elderly)
- ward 27 (orthopaedic rehabilitation)
- ward 30 (medicine for the elderly)
- ward 38 (medicine for the elderly)
- ward 43 (cardiology), and
- ward 64 (general surgery).

Before the inspection, we reviewed NHS Greater Glasgow and Clyde's self-assessment and obtained information about Glasgow Royal Infirmary 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 decided to focus the inspection on dementia and cognitive impairment, and preventing and managing pressure ulcers.

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

We also carried out patient interviews and used patient and carer questionnaires. We spoke with 19 patients during the inspection. We received completed questionnaires from 40 patients and three family members, carers or friends.

As part of the inspection, we reviewed 30 patient health records to ensure the care planned and delivered was as described in the care plans. For this inspection, we reviewed 26 patient health records for dementia and cognitive impairment. We also reviewed 26 patient health records for preventing and managing pressure ulcers.

Areas of strength

We noted areas where NHS Greater Glasgow and Clyde was performing well in relation to the care provided to older people in acute hospitals. Patients who we spoke with were happy with the care they received during their stay in Glasgow Royal Infirmary and we observed some good interactions between staff and patients.

There is an older people's mental health liaison service that works with the community mental health teams. This enhances the continuity of care between the hospital and the community. NHS Greater Glasgow and Clyde has appointed a nurse consultant in conjunction with Alzheimer's Scotland to develop dementia care within the NHS board.

There is a tissue viability service within Glasgow Royal Infirmary. As part of the service, each ward has a tissue viability link nurse.

Areas for improvement

However, we did find that further improvement is required in the following areas.

The environment within Glasgow Royal Infirmary does not consistently allow for the dignity of patients to be respected. For example, patients in some wards cannot access a toilet if they require the assistance of two nurses or use a walking frame. In some areas, there is a lack of bathing and showering facilities. Where bathing and showering facilities were available, they do not always preserve the dignity of patients.

A number of assessments of cognitive impairment and pressure areas were poor or had not taken place. Without an assessment of the individual needs of a patient, there is no evidence to demonstrate that the care provided is appropriate. Documentation regarding the care provided to patients was not always completed or correct.

This inspection resulted in four areas of strength, 17 areas for improvement and one area for continuing improvement. A full list of the areas for improvement can be found in Appendix 1 on page 14.

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

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>.

We would like to thank NHS Greater Glasgow and Clyde and in particular all staff at Glasgow Royal Infirmary for their assistance during the inspection.

3 Our findings

Treating older people with compassion, dignity and respect

We inspected a mix of single sex and mixed sex wards. In wards that were mixed sex, patients were accommodated in single sex bays or single rooms. Bed screens were available and in use to maintain the dignity of patients and to provide treatment in privacy. All wards we visited had a nurse call system in use. We observed that the call handsets were placed near to patients to make them accessible for patients to use.

Many of the patients we saw during the inspection wore hospital gowns rather than their own clothes. The gowns did not preserve their privacy and dignity when walking around the ward. Some male patients were wearing poorly fitting pyjama bottoms that had to be held up when they were walking.

Patient comments

Through our patient surveys and patient interviews, patients had the opportunity to give us their opinion of the care they received. All patients interviewed told us that they had received good care, attention and treatment.

- 'Very pleased with the care and attention received'
- 'I will miss [the] ward. Care has been good.'
- 'First time in the Royal and I rate them 100/100. Kind caring and know what the patient looks for.'
- 'I find the staff and doctors very helpful and caring.'

The majority of patients (10 out of the 13 patients asked) also stated they and their carers had been informed about their care.

Some patients, relatives and carers told us of some concerns they had.

- One patient told us, 'Though I am elderly I have no problems with personal hygiene. So it would be helpful [for] other patients like me [if] there was a walk in shower facility.'
- One patient commented that patient buzzers were not always responded to straight away.

Patient and staff interaction observations

We used a formal observation tool in six of the wards inspected. The majority of interactions (28 out of 56) we observed were neutral. Neutral interactions are those that neither enhance nor undermine a patient, but allow a task to be performed, such as the completion of care tasks. We also saw a number of examples of positive caring behaviour (25 out of 56) during staff interactions with patients. This was across all staff groups including nurses, healthcare assistants, physiotherapists and domestic staff. The following examples of interactions observed demonstrate how we would expect to see staff and patients interacting.

- A staff member asked a patient if it would be okay to check a dressing. They then drew the curtains around the patient's bed to deliver care in private. When the staff member was finished, they apologised for disturbing the patient.
- A staff member spoke discretely to a patient to encourage them to take more food and fluids.
- A staff member crouched down beside a patient to be at their level while discussing when the patient would be 'up and about' again.

- A physiotherapist introduced themselves to a patient and asked how she was doing. They bent closer to listen to the patient. They explained about getting the patient home and the physiotherapy that would be needed. They showed the patient their new walking stick and laughed with the patient.

Although the majority of interactions we observed were neutral or positive, we did see three examples where staff interactions with patients could be improved. These included the following:

- A patient was receiving a bed bath from a member of staff with the curtains drawn when another member of staff entered the bed area without asking to let the other staff member know there was a call waiting for them.
- A staff member walking to a patient's bed and drawing the curtains around the bed without an explanation to the patient.

We also found use of inappropriate language in patient health records, for example:

- patients were described as 'pleasantly confused' on three occasions, and
- in one health record, staff referred to bed rails on an adult bed as 'cot sides'.

Patient environment

We noted several areas for improvement relating to the patient environment within Glasgow Royal Infirmary.

In five wards, there was a lack of choice and limited availability of bathing facilities. On one ward, two baths were available for 32 patients. There was one shower on the ward, but this was an en-suite facility for an isolation room and not available to the whole ward. A patient on this ward told us they were used to having a bath every day at home, but had not been able to whilst in hospital. The same patient also told us that they had prepared for a bath that morning, but there was no hot water on the ward so had been unable to have one. From our observations, most patients were given a basin at the bedside to wash with. Two patients told us this was not their choice, but felt they had no option. On another ward, there was one working shower for 15 patients. The shower was in a large room that did not have a lockable door and there was limited indication that this was a shower area. There was no shower curtain available to preserve the modesty of patients should someone walk into the room.

On two wards, toilet facilities were laid out in a way that patients could not use them if they required the assistance of more than one member of staff or used walking frames. These patients had to use commodes at the bedside.

At the end of one ward, a patient bed was adjacent to an area used to store equipment. There was nothing in place to separate the area from the patient. The patient was at risk of falling and a risk assessment required all tripping hazards to be removed from the immediate environment. In other wards, trolleys containing patient health records were left in the corridors obstructing the path of patients using handrails to walk.

Areas for improvement

1. NHS Greater Glasgow and Clyde should ensure that staff involved in patient care are not unnecessarily interrupted by other members of staff.
2. NHS Greater Glasgow and Clyde should review the bathing and toilet facilities in Glasgow Royal Infirmary to ensure that patients are able to choose and access the facilities they require to maintain privacy and dignity.
3. NHS Greater Glasgow and Clyde should remove clutter in wards and corridors to make it easier for patients to move around the wards.

Dementia and cognitive impairment

Older people's mental health liaison service

There is an older people's mental health liaison service within Glasgow Royal Infirmary. The team is made up of one doctor and two nurses. The doctor works for the liaison service two mornings each week and the nurses are available Monday to Friday 8am–5pm. The team provides services for the Glasgow Royal Infirmary site as well as patients on other hospital sites.

This service provides a link between community mental health teams and medical staff within the hospital. This helps provide continuity in the care given to people who come into hospital and are already known to services in the community. We were told during the inspection that community mental health nurses also visit their patients who are in hospital to help assess any potential decline in their cognitive functioning.

This service has also developed and distributed guidance for staff relating to the assessment of mental capacity as well as diagnosing acute confusion and delirium.

Alzheimer's Scotland nurse consultant

An Alzheimer's Scotland nurse consultant is employed in NHS Greater Glasgow and Clyde. The post holder provides specialist knowledge, training and strategic leadership on dementia care across all acute hospitals in NHS Greater Glasgow and Clyde. The Alzheimer's Scotland nurse consultant had been in post for 8 weeks at the time of inspection and provides expert clinical advice in complex cases.

The post holder is planning to develop six demonstrator wards throughout NHS Greater Glasgow and Clyde to highlight good practice in dementia care.

Assessment

NHS Greater Glasgow and Clyde's self-assessment states that patients over 65 years of age, who are triaged in the accident and emergency department, are assessed using a mental health assessment. A copy of this assessment is then kept in the patient health record and accessible to all staff.

We found that cognitive assessments were not routinely taking place on admission. Of the 26 patient health records reviewed during the inspection, we were only able to identify five patients who had been assessed for cognitive impairment on admission. It was often difficult to determine when the assessment had been carried out as the assessments were not always dated or timed. There were also five patients who had not been assessed at any point during their admission. This included patients who were identified by staff as having a

cognitive impairment. In one case, an assessment from a previous admission several months before was used for the current admission.

Individual care planning

From the patient health records we reviewed, there was no evidence of how cognitive assessments informed further care. We did not find evidence of patients assessed as having a cognitive impairment being referred to the older people's mental health liaison service as described in the NHS board's self-assessment.

In the patient health records reviewed there was no evidence that care plans were individualised to the specific care needs of patients identified as having a cognitive impairment to allow staff to meet those needs. Although there was some evidence of challenging behaviour care plans, these were generic and did not relate to the individual patient.

NHS Greater Glasgow and Clyde's self-assessment states that there is a range of person-centred assessments in place to inform individualised care planning. Within the rehabilitation and assessment directorate, the 'getting to know you' document is in place. This helps patients and their carers provide key information to staff. This can include information on family members, interests and things that reassure the patient when they are anxious.

However, it was unclear what person-centred assessments were in use throughout the rest of the hospital to inform individualised care planning.

Adults with incapacity

NHS Greater Glasgow and Clyde has a consent policy on healthcare assessment, care and treatment. The policy outlines the process staff should follow in order to gain consent from patients for the treatment they receive. The policy includes a section on how to manage patients who are unable to consent due to lack of capacity. This would involve an assessment of the individual's capacity and completing an adult with incapacity form if the person was deemed not to have capacity. The form provides authorisation to treat patients who do not have capacity to make decisions regarding their own treatment.

Adult with incapacity forms were inconsistently completed throughout the hospital. In some patient health records we found that care plans had been put in place for adults with incapacity, but the necessary adult with incapacity form had not been completed. For one patient, four forms had been completed for three different procedures. None of the forms specified the use of medication. There was not always a documented assessment of the patient's capacity to consent to treatment to accompany the adult with incapacity form.

During the inspection, we identified a patient whose discharge was delayed due to the complexity of their individual needs. After discussion with us, the ward contacted the Mental Welfare Commission for advice. We also informed the Mental Welfare Commission of this situation independently.

Environment

NHS Greater Glasgow and Clyde is developing a signage policy to assist in the delivery of appropriate signage for older people and people with cognitive impairment. During the inspection, we noted that steps had been taken to improve signage. For example, signs had been put in place to help patients more easily identify toilets and bathrooms.

Elderly care wards were situated on the upper floors of the hospital. They had poor natural light and no access to outside areas for patients. This is particularly important for those patients who had a delayed discharge.

We observed that there were few personal items to help patients with cognitive impairment recognise their bed area.

There was also no stimulation for patients with cognitive impairment. There was a lack of television and radio facilities in medicine for the elderly and orthopaedic rehabilitation wards and few areas for patients to sit away from their beds. Patients who were delayed from being discharged had limited access to meaningful activity to help them maintain their cognitive function.

Areas of strength

- There is an older people's mental health liaison team working with medical staff and community mental health teams to enhance the continuity of care for patients with cognitive impairment.
- An Alzheimer's Scotland nurse consultant has been appointed in dementia care, with funding support from Alzheimer's Scotland.

Areas for improvement

4. NHS Greater Glasgow and Clyde must ensure that all older people who are treated in accident and emergency, or are admitted to hospital, are assessed for cognitive impairment.
5. NHS Greater Glasgow and Clyde should ensure that patients identified as having a cognitive impairment have a care plan to identify their specific needs and to outline how staff should meet these needs.
6. NHS Greater Glasgow and Clyde must ensure that systems are in place to request and record key personal information about people with dementia and ensure this information is shared with staff who are in direct contact with them.
7. NHS Greater Glasgow and Clyde should ensure that all patients identified as having a potential cognitive impairment also have their capacity to consent to treatment assessed.
8. NHS Greater Glasgow and Clyde should ensure that the appropriate legislation is used to allow staff to give treatment when patients are deemed not to have capacity.
9. NHS Greater Glasgow and Clyde should ensure that staff have access to training on capacity and the use of Adult with Incapacity legislation.
10. NHS Greater Glasgow and Clyde should ensure that meaningful activity is available for patients in hospital for a number of weeks who are able to participate to help them maintain their cognitive function.

Areas of continuing improvement

- a. NHS Greater Glasgow and Clyde should continue to develop signage throughout Glasgow Royal Infirmary to help those with dementia, cognitive impairment and sensory loss find their way around the ward and hospital.

Preventing and managing pressure ulcers

Tissue viability nurse service

NHS Greater Glasgow and Clyde has a dedicated tissue viability service. There are seven tissue viability nurses on the team, one of whom is based in Glasgow Royal Infirmary. There is also a tissue viability link nurse in each ward in the hospital. The link nurses receive updates, attend training and are expected to keep colleagues up to date with current practice in preventing and managing pressure ulcers.

When a patient is referred to the tissue viability nurse service, the aim of the service is to see them within 24 hours. We saw records of two patients who had been referred to the tissue viability service. In both cases, the referral had been followed up and the tissue viability nurse had documented the advice and treatment recommended. There was also evidence of subsequent visits to review the patients' care and treatment.

Assessment

NHS Greater Glasgow and Clyde use the adapted Waterlow tool to assess patients at risk of developing pressure sores within 6 hours of admission. Of the 26 patient health records reviewed, the majority had an adapted Waterlow assessment completed. However, it was not always clear if the assessment had been completed within the 6-hour timescale. We also found a number of assessments had not been completed correctly. For example, one patient was described as mobile while they were chair bound and their skin was described as intact although their skin was broken. This resulted in an inaccurate calculation of their risk of developing a pressure ulcer. The patient subsequently developed a pressure ulcer.

Equipment

Every bed in the hospital has a specialist foam mattress as standard and half of the beds in the hospital are profiling, meaning they can be adjusted to re-position the patient and help them sit up. If a patient's assessment indicates that they need additional specialist equipment, this is provided by an external company. Staff told us that only five wards in the hospital can fully access this service at the weekend. These wards can order a piece of equipment at the weekend and would receive it. Others could order a piece of equipment at the weekend, but it would not be delivered until the Monday. Senior management told us that all wards in the hospital can access additional specialist equipment at the weekend.

Care plans

Care plans were not individualised and did not reflect the adapted Waterlow assessments. There were no care plans that detailed how each individual pressure ulcer should be treated. We saw evidence of evaluation of some pressure ulcers. However, it was unclear if every pressure ulcer was being reviewed, how often it was being reviewed, the current status of the pressure ulcer and what treatment was currently prescribed. We also noted that it was not always clear from care plans what interventions were in place to reduce the risk of pressure areas developing. It was not always clear what pressure relieving equipment should be in place or how often a patient should be repositioned.

Patients who are at risk of developing pressure ulcers and who are assessed as needing regular position changes must have any repositioning recorded. This would detail the

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position changes that have taken place over the course of the day. We did not find evidence of repositioning charts or records of regular skin examinations.

We also found that three patients who had pressure ulcers had no wound assessment charts.

Audit

A pressure ulcer safety cross is used to give an 'at a glance' view of the number of patients who develop a pressure ulcer in a ward. Each numbered box on the cross indicates a day of the month. Where a box is green, no patients have been admitted to the ward with a pressure ulcer or have developed a pressure ulcer on the ward that day. Where a box is coloured orange, one or more patients who already have a pressure ulcer have been admitted to the ward on that day. Where a box is red one or more patients have acquired a pressure sore while on the ward. The safety cross is often displayed on public notice boards at the entrance to a ward. This can provide public reassurance about pressure area care.

In two wards, the safety crosses were inaccurately completed. In one ward, we found that a patient had acquired a pressure ulcer whilst on the ward. The safety cross was not completed to reflect this. On another ward, a patient was transferred to the ward with a pressure ulcer. Again, the safety cross was not completed to reflect this.

Areas of strength

- There is a dedicated tissue viability service in Glasgow Royal Infirmary.
- There is a tissue viability link nurse in each ward.

Areas for improvement

11. NHS Greater Glasgow and Clyde should ensure that adapted Waterlow assessments are accurately completed and calculated.
12. NHS Greater Glasgow and Clyde must ensure that all staff who have identified patients who need specialist pressure relieving equipment are aware they are able to access this at the time of need.
13. NHS Greater Glasgow and Clyde must ensure that each pressure ulcer has a clear plan of care with planned review dates and that each review is accurately documented.
14. NHS Greater Glasgow and Clyde must ensure that, where regular position changes have been prescribed, these are documented and include the frequency of changes.
15. NHS Greater Glasgow and Clyde must ensure that regular skin inspections are documented for patients assessed as needing them.
16. NHS Greater Glasgow and Clyde should ensure that pressure ulcers are recorded on a wound chart in line with local policy.
17. NHS Greater Glasgow and Clyde should ensure that the tissue viability safety cross is completed in line with staff guidance in all wards.

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

NHS Greater Glasgow and Clyde:

- | | |
|----------|--|
| 1 | should ensure that staff involved in patient care are not unnecessarily interrupted by other members of staff (see page 9). |
| 2 | should review the bathing and toilet facilities in Glasgow Royal Infirmary to ensure that patients are able to choose and access the facilities they require to maintain privacy and dignity (see page 9). |
| 3 | should remove clutter in wards and corridors to make it easier for patients to move around the wards (see page 9). |

Dementia and cognitive impairment

NHS Greater Glasgow and Clyde:

- | | |
|----------|--|
| 4 | <p>must ensure that all older people who are treated in accident and emergency, or are admitted to hospital, are assessed for cognitive impairment (see page 11).</p> <p>This is to comply with the Clinical Standards for Older People in Acute Care, Standard 2.</p> |
| 5 | should ensure that patients identified as having a cognitive impairment have a care plan to identify their specific needs and to outline how staff should meet these needs (see page 11). |
| 6 | <p>must ensure that systems are in place to request and record key personal information about people with dementia and ensure this information is shared with staff who are in direct contact with them (see page 11).</p> <p>This is to comply with Standards of Care for Dementia Scotland, page 26.</p> |
| 7 | should ensure that all patients identified as having a potential cognitive impairment have their capacity to consent to treatment assessed (see page 11). |
| 8 | should ensure that the appropriate legislation is used to allow staff to give treatment when patients are deemed not to have capacity (see page 11). |
| 9 | should ensure that staff have access to training on capacity and the use of Adult with Incapacity legislation (see page 11). |

10 should ensure that meaningful activity is available for patients in hospital for a number of weeks who are able to participate to help them maintain their cognitive function (see page 11).

Preventing and managing pressure ulcers

NHS Greater Glasgow and Clyde:

11 should ensure that adapted Waterlow scores are accurately completed and calculated (see page 13).

12 must ensure that all staff who have identified patients who need specialist pressure relieving equipment are aware they are able to access this at the time of need (see page 13).

This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers (March 2009) (Section 6: mattresses, chairs and cushions).

13 must ensure that each pressure ulcer has a clear plan of care with planned review dates and that each review is accurately documented (see page 13).

This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers (March 2009) (Section 7: promoting healing).

14 must ensure that, where regular position changes have been prescribed, these are documented and include the frequency of changes (see page 13).

This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers (March 2009) (Section 5: positioning).

15 must ensure that regular skin inspections are documented for patients assessed as needing them (see page 13).

This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers (March 2009) (Section 1: skin examination, assessment and care).

16 should ensure that pressure ulcers are marked on a wound chart in line with local policy (see page 13).

17 should ensure that the tissue viability safety cross is completed in line with staff guidance in all wards (see page 13).

Areas for continuing improvement are improvements that the NHS board has already identified and started to address. We acknowledge the work carried out by the NHS board at the time of inspection and encourage progress in these areas.

Areas for continuing improvement

NHS Greater Glasgow and Clyde:

- | |
|--|
| a should continue to develop signage throughout Glasgow Royal Infirmary to help those with dementia, cognitive impairment and sensory loss find their way around the ward and hospital (see page 11). |
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Appendix 2 – Details of inspection

The inspection to **Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde** was conducted from **Wednesday 2 May** to **Friday 4 May 2012**.

The inspection team consisted of the following members:

Ian Smith

Regional Inspector

Brian Auld

Associate Inspector

Gareth Marr

Associate Inspector

Julie Tulloch

Associate Inspector

Gerry McKay

Public partner

Marguerite Robertson

Public partner

Supported by:

Sara Jones

Project Officer

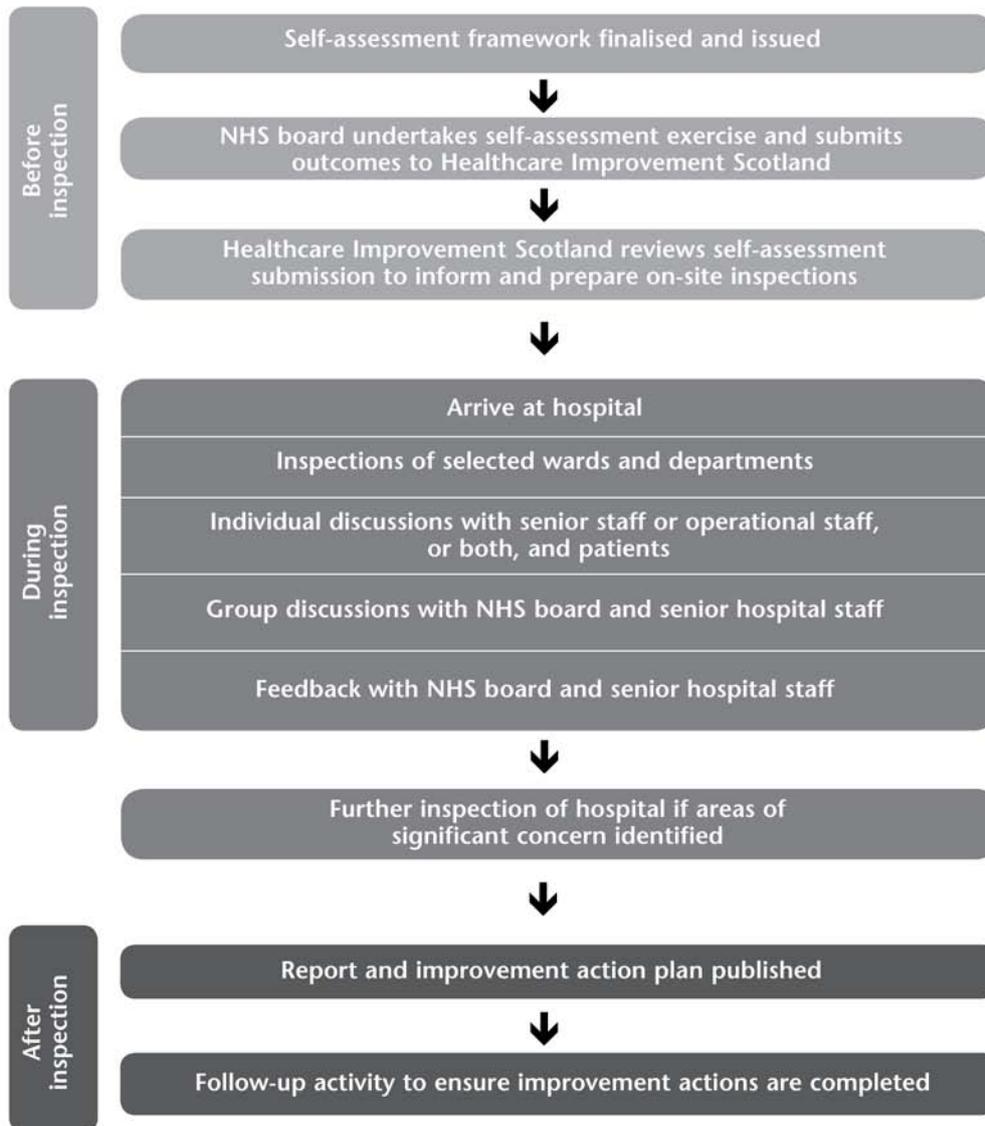
Appendix 3 – List of national guidance

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)
- **Health Department Letter (HDL) (2007)13: Delivery Framework for Adult Rehabilitation - Prevention of Falls in Older People** (Scottish Executive, February 2007)
- **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

Abbreviation

CSBS	Clinical Standards Board for Scotland
HDL	Health Department Letter
SIGN	Scottish Intercollegiate Guideline Network

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 | Elliott House | 8-10 Hillside Crescent | Edinburgh | EH7 5EA

Telephone 0131 623 4300

Email hcis.chiefinspector@nhs.net



www.healthcareimprovementscotland.org

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

