
Care for Older People in Acute Hospitals

November 2014
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1 Executive summary

This report provides a review of our findings from inspections looking at the care of older people in acute hospitals carried out from May 2013 to July 2014. This is the third overview report since inspections began in February 2012.

The inspection process assures the public that care is of a high standard and is delivered in a person-centred, safe and effective way. Findings from inspections are also being used to help drive improvement in the care delivered. For this report, we have identified some of the improvements being made in relation to inspection findings, many of which are being supported by our national improvement programmes including the older people in acute care improvement programme. This has run in tandem with the older people in acute hospitals inspection process. We have focused on improving care in areas of frailty and delirium as well as providing advice and guidance to inspection teams and NHS boards.

Examples of improvement activity carried out by various NHS boards are outlined as ‘improvement highlights’ in the report. Much of the focus of this work has been on improving care for people with dementia.

During our inspections, we saw increased awareness of the issues facing older people in hospitals. However, we need assurance that the care delivered demonstrates a person-centred approach that is both safe and effective. We consistently saw that patients were treated with compassion, dignity and respect. However, we found a lack of information documenting the care given to show that patients’ care needs were always met.

The capacity and flow of patients in acute hospitals is an area that is an ongoing concern. This is how NHS boards manage bed occupancy within the hospital, particularly during times when the hospital is busy. We have seen examples in the hospitals inspected where work is being carried out to alleviate these issues. However, the process of ‘boarding’ of patients is still widespread in Scotland.

A new methodology for the inspection of the care of older people has been developed. This provides a more transparent approach to support the robust inspection of hospitals. Clinical experts and clinical partners from across NHSScotland are also involved to help inform the inspections. This approach has been welcomed by the NHS boards and is now being implemented.

Another important step in improving the care of older people is to update the older people in acute care standards. The revised standards will be published in March 2015.

We have made several recommendations in this report on page 24 for NHS boards to implement. We will continue to follow these up at future inspections.
2 Introduction

2.1 Context – our scrutiny work

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.

The aim of these inspections is to provide public assurance that the care of older people in acute hospitals is of a high standard and to encourage improvement where it is needed. We were asked to carry out these inspections because of our experience of inspecting acute hospitals throughout NHSScotland.

Our teams include a senior inspector, inspectors and clinical advisors from NHS boards who provide us with clinical advice and support. Public partners also join us on our inspections to speak with patients, carers and public representatives to make sure their views are heard. More information about our inspection process can be found in Appendix 2.

Ensuring that older people are treated with compassion, dignity and respect is a focus on all our inspections. We also look at one or more of the following areas on each inspection:

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

As there is currently no national guidance to measure performance against falls prevention and management, we are not assessing against this at this time. Falls prevention and management will feature in the revised older people in acute care standards. The revised standards will be published in March 2015. We will then incorporate falls prevention and management into our inspection activity.

We have now completed our initial programme of announced inspections to each of the 14 territorial NHS boards, and the NHS National Waiting Times Centre (Golden Jubilee National Hospital, Clydebank). Our findings have highlighted areas of good practice and provided each NHS board with valuable information which they can use to make improvements to the care of older people in their acute hospitals.

Older people in acute care inspection revised methodology

To ensure the focus of inspection is about improving standards of care, we have reviewed and improved the way we engage with NHS boards during the inspection process. This took account of the 19 recommendations made in the report of the care of older people in acute hospitals inspection methodology review group (Healthcare Improvement Scotland, 2013).¹

¹ Healthcare Improvement Scotland: Report on the review of the methodology and process for the inspection of the care of older people in acute hospitals. (November 2013)
The revised inspection process includes a revised self-assessment. This is when the NHS boards provide evidence against 11 outcomes. This now differs from the previous self-assessment to make sure there is a stronger focus on patient outcomes. For example:

**Screening and initial assessment**

**Outcome 1:**

The patient is supported to return home (or to a homely setting or care service) or if necessary admitted directly to the correct ward (in this or other appropriate hospital).

Ensuring older people are screened and assessed appropriately on arrival at hospital, including medicines reconciliation. Where initial assessment and screening identifies care needs, a multidisciplinary team completes a detailed assessment without delay. Once the assessments are completed, admission or discharge occurs promptly.

Also, the revised methodology introduces two important stages: an annual pre-inspection meeting with the NHS board to discuss their self-assessment and the improvements they are making for the care of older people in the acute hospitals. This meeting provides important context and focus for unannounced inspections within the NHS board area. We are also carrying out post-inspection follow-up visits to discuss NHS boards’ improvement plans.

We issued a revised outcomes focused self-assessment to NHS boards in August 2014. We also carried out two test inspections using the new methodology. We then implemented the new methodology in October 2014.

From now on, our inspections will be **unannounced**. We will continue to publish our findings and we will update the style of our reports to reflect our new inspection process.

### 2.2 Context – our improvement work

We also have a role as the national healthcare improvement organisation for Scotland in supporting healthcare providers to deliver safer, more effective and more person-centred care. We are committed to working in partnership with healthcare providers to make improvements for patients. Our strategy document, *Driving improvement in healthcare: Our strategy 2014–2020*[^2], states that: ‘One thing is very clear to us: simply criticising the standards of care is not enough to make sure that change happens.’ We want to encourage and challenge healthcare providers as well as advise and offer practical support when needed.

Our older people in acute care improvement programme is currently funded until March 2016. This complements the scrutiny (inspection) work we carry out. We help NHS boards to learn from inspections to drive improvement in the care of older people in acute hospitals. The two main areas we are focusing on in our improvement programme are:

- care co-ordination - focusing on identifying and managing frailty, and
- cognitive impairment - focusing on identifying and managing of delirium.

Frailty is described as ‘a decreased ability to withstand illness without loss of function’[^3]. Frail older people usually have longer stays in hospital, higher mortality and rates of readmission, and they are more likely to be discharged to residential care.

Delirium is a recognised problem in older people that is frequently overlooked or misdiagnosed and is very distressing to individuals and their families and carers. It is a state of mental confusion which can be caused by illness, surgery and medications. It often starts suddenly, but usually lifts when the condition causing it gets better. It can be frightening - not only for the person who is unwell - but also for those around them. Those who develop delirium may need to stay longer in hospital, may have more hospital-acquired complications, such as falls and pressure ulcers, may be more likely to be admitted to long term care if they are in hospital, and may be more likely to die\(^4\).

We are working together with healthcare teams from across acute hospitals in Scotland to:

- test and introduce new tools with the aim of improving screening for frailty and improving early management of delirium
- share experience, expertise and examples of good practice in improving care for older people
- build capacity and capability for improvement, and
- support local improvement work.

For example, we recommend that older patients are screened for frailty on admission to hospital. Where individuals are identified as frail, a comprehensive geriatric assessment should be carried out within 24 hours. Working with colleagues from across Scotland, we developed a prototype frailty screening tool and are working with teams in a number of NHS boards to test approaches to identifying and managing frailty. Testing has taken place with teams across NHSScotland to improve identification of frail older people admitted to acute hospitals.

We also deliver, in collaboration with NHS boards, a range of national improvement programmes, including the Person-Centred Health and Care Collaborative and the Scottish Patient Safety Programme. One aim of the programme is to further improve the safety of people in acute adult healthcare. We support and measure implementation of the Scottish Patient Safety Programme in hospitals across NHSScotland. The programme is concentrating on priority areas which can cause harm to older people including falls and pressure ulcers. We are working in partnership with a number of NHS boards to test approaches to reducing harm in these areas.

### 2.3 Previous overview reports

We published a report in October 2012\(^5\) which covered the first eight inspections we carried out for the care of older people in hospitals. That report covered inspections which took place from February 2012 to July 2012.

We published a second report in July 2013\(^6\) which covered the next eight inspections we carried out for the care of older people in hospitals. That report covered inspections which took place from August 2012 to April 2013.

All our inspection and overview reports are available on our website:

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

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\(^5\) Healthcare Improvement Scotland: Care for older people in acute hospitals. Six-monthly report (February-July 2012)

\(^6\) Healthcare Improvement Scotland: Care for older people in acute hospitals. Overview report (August 2012-April 2013)
2.4 Current progress report

This report covers the inspection period from May 2013 to July 2014. During this time, we carried out 15 inspections to 13 hospital sites. Seven of these inspections were announced and six were unannounced (see Appendix 1).

The remaining two inspections were unannounced follow-up inspections. We chose to carry out these unannounced follow-up inspections because of issues we found during the hospitals’ initial inspection.

This report also makes reference to improvement activity across NHSScotland that we became aware of during this inspection period.

2.5 Patient health records

During the last 15 months of inspection, we reviewed 468 patient health records. Of these:

- 94% (442) were reviewed for dementia and cognitive impairment
- 86% (402) were reviewed for nutritional care and hydration, and
- 69% (324) were reviewed for preventing and managing pressure ulcers.

2.6 Public partner involvement

Our public partners work closely with us to help develop the way we work as our inspection programme evolves. This has included:

- developing a more in-depth set of patient questions to capture the information relevant to the focus of the inspection
- helping to revise the relative and carers questionnaire we use on inspections
- helping to develop the new methodology for our older people in acute hospitals inspections, and
- testing that methodology by being part of the team on the NHS board visits and leading focus group discussions with NHS boards on how they are engaging with the public and patient representatives.

Feedback from patients and visitors

We ask patients to complete anonymous patient questionnaires where we ask them about the care they have received whilst in hospital. Our public partners also speak with patients and their visitors and carers during the inspection.

In total, we received 650 completed patient questionnaires. We also carried out 338 interviews with patients and six interviews with visitors. In general, patients and their visitors were positive about the care older people had received during their stay in hospital. On average, 99% of patients who completed our questionnaires said the quality of care they received was good.

Some patients commented:

- ‘As a patient you are always treated with a smile wherever you enter. All staff keep you well informed of what is going to happen. All questions are answered.’
- ‘During my stay, they have cared for me and supported me emotionally, with great care.’
• ‘Staff have went above the call of duty to provide an excellent high standard of care, not only to myself but to my family. Second to none.’

• ‘During my stay, I have been treated with care and respect. Many staff go well beyond normal care in helping me and my husband. The idea of carers/family being involved in assisting with patient care is excellent for both the family and the patient.’

However, some patients and visitors told us about some concerns they had.

• ‘I feel that staff do not always respond in a timely manner which in turn creates more work for them. I don't always feel that staff check on me and I am left to attend to myself which makes me feel that I don't want to ask for help and that I feel I am an inconvenience at times.’

• ‘Father unable at present to communicate. Whilst visiting, soiled and messy on regular visits. Staff mention whilst approached that they are just on duty and apologise.’

• ‘... during the night - take too long to come when I need to go to the toilet.’

• ‘Environment on the ward can be quite chaotic at times with doctors, visitors, cleaners working, meal times served etc often all at the one time. Allocating separate times for these various activities would lead to a calmer environment for patients.’
3 Key findings

This part of the report follows the same style as our inspection reports, using similar headings. In each section we have highlighted areas of strength, areas for continuing improvement and areas for improvement from the inspections we carried out from May 2013 to July 2014.

Areas of strength: These are areas of good practice which are identified during the inspection. We acknowledge these strengths and encourage the NHS board to continue to deliver this standard of care.

Areas for continuing improvement: These 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 improvement: These 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.

We also refer to improvement activity across NHSScotland that we became aware of during this inspection period.

3.1 Evidence of care

To ensure patients receive the correct care while in hospital, it is essential to plan the patients care. The following process should be used:

Assessments

Person-centred care sees patients as equal partners in planning, developing and assessing care to make sure it is appropriate for their needs. It involves putting patients and their families at the heart of all decisions. Assessments are carried out on admission to hospital to establish a baseline picture of what care the patient will require and for staff to anticipate any issues that patient might develop whilst in hospital. The assessment is a formal process that takes account of areas such as nutritional status, falls and cognitive impairment.

Care planning

The care plan is a legal document that details what care the patient should receive whilst in hospital. It should not be a list of tasks that should be carried out on the patient. Care planning is a result of the assessment process and communicating with the patient, carer or relatives to determine what the specific care needs of the patient are.

Care implementation

Care rounding is a structured approach to the delivery of fundamental care following the assessment of a patient’s needs.
Evaluation
An evaluation of the care is based on the level of risk that the patient has. This is based on assessments. This must be documented and reflected in the care plan. Throughout our inspections, we have consistently found examples of where patient care is not planned and delivered in a person-centred manner and has, on occasions, given us concerns about the assurance of the care that is being delivered.

3.2 Treating older people with compassion, dignity and respect
We looked at how older people were being treated with compassion, dignity and respect in all of the inspections we carried out from May 2013 to July 2014.

Areas of strength
We use a formal observation tool on all inspections to observe interactions between staff and patients. In all hospitals inspected, we saw examples of warm, caring and meaningful interactions between staff and patients. Care was carried out in a way that maintained patient dignity and respect.

In the majority of hospitals inspected, we found that the wards were generally calm and organised. This contributed to patients’ care being carried out in a way that maintained patient dignity and was respectful. The majority of wards were light, bright and fresh smelling and most ward corridors were free from clutter and obstructions. In one hospital, patients were seen to have their own personal items such as photographs, a cushion and bedcover. This provided them with familiar items to give comfort and reassurance as well as helping them to identify their bed space within the ward.

In the majority of hospitals, we saw that information displayed about personal care needs, either above patient beds or on whiteboards in the corridor areas, was kept to a minimum to maintain patients’ privacy. For example, information about patients’ mobility or nutritional needs was often displayed. Patients’ medical conditions were not displayed.

Care and comfort rounding was in place in many hospitals 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.

Many of these areas of strength are supplemented by effective leadership, good communication between staff groups and with patients, and good support in place for patients and carers. For example:

- Staff were aware of their roles and responsibilities and the wards appeared to be well organised. Staff told us they felt well supported and we were told that some senior managers carry out frequent ‘walkronds’ within their hospital. This allowed any issues from patients and staff to be raised directly with them.

- We saw examples of support for patients’ relatives and carers in a variety of formats, including posters, open visiting times, evidence of families being actively involved in their relatives’ care and the inclusion of public representatives at NHS board committee meetings.

- We saw ‘You said, we did’ comment boards on display in some hospitals. These boards are used to display patients’ comments and highlight what the ward has done to improve the patient experience during their stay in the ward.
Areas for continuing improvement

One hospital has put various initiatives in place to reduce waiting times and pressure on the accident and emergency (A&E) department. This included the introduction of a GP assessment area and the pilot of a frail elderly pathway. The purpose of the pathway is to identify frail elderly patients as early as possible to make sure they receive timely co-ordinated care.

One hospital is working with the Scottish Ambulance Service to improve the service to patients. We had been told that patients are often moved from one hospital to another and this can sometimes take place in the late evening. An internal transfer system has been introduced, using the NHS board's own patient transport, to prevent late transfers.

During a follow-up inspection, we found that improvements had been made to address issues we had previously identified about patient capacity and flow. The hospital has now introduced twice daily capacity meetings and a discharge hub team has been set up which has encouraged communication between clinical teams and managers. This provides a forum for all staff to identify any issues that will affect patient care.

Areas for improvement

In some of the hospitals inspected, we found examples where staff interactions with patients could be improved. We heard staff using inappropriate language, such as referring to patients by their bed number rather than their name.

We saw some examples where patient dignity could be improved. For example, we saw patients wearing theatre gowns rather than their own clothing and patients being transferred through the wards on shower chairs or commodes rather than wheelchairs.

In some of the hospitals inspected, we saw occasions when clinical staff were not always complying with the national do not attempt cardiopulmonary resuscitation (DNACPR) policy and were not completing the appropriate documentation correctly.

We saw examples of care and comfort rounding in place in some of the hospitals inspected. However, we saw that the documentation to accompany care and comfort rounding was completed inconsistently. This does not give assurance that care has been provided. The implementation of care and comfort rounding was also not supported by adequate personalised care planning and evaluation.

In the majority of hospitals inspected, we found little evidence of proactive discharge planning. Effective discharge planning begins on, or shortly after, admission and is a continual process. We found widespread examples of patients experiencing delayed discharges. This is when a patient is medically fit to be discharged but is waiting for other services such as nursing and residential care and appropriate care within the patient's home. We noted that many patient health records had a discharge planning sheet in them. However, the majority had no information on them and none of them indicated an expected discharge date.

We found that boarding takes place in most of the hospitals inspected. Boarding is when patients are moved from one ward to another to meet the needs of the service not because of the patient’s clinical needs. We found examples where patients with known dementia and increased confusion had several ward moves. Although some of these moves were due to clinical need, some were documented as being due to capacity issues in the hospital. In one hospital, a surgical ward had six medical patients who had been boarded from another ward.
In our patient surveys, some patients commented on this.

- ‘Transfer from one ward to another after midnight. [This was] upsetting.’
- ‘Family should be involved in discussions [regarding] treatment and care when memory issues are present. Patients should not be moved without prior consultation and discussion with family.’

National improvements in treating patients with compassion, dignity and respect

We lead the Person-Centred Health and Care Collaborative, part of a Scotland-wide programme of work aimed at improving healthcare services so that they are focused on patients, their families and carers. The collaborative aims to improve patients’ experiences at the point of care. The overall approach of the collaborative is to listen to the experiences of people who use services and use their feedback to drive improvement and make care more person-centred.

For example, we are aware that one NHS board is testing a tool called ‘What’s important to me?’. Staff will discuss with patients, their families, carers and relatives to establish what is important to the person during their hospital stay. The purpose of this is to make sure that the patient’s care is personalised to meet their individual needs.

3.3 Dementia and cognitive impairment

Dementia is a word used to describe a group of symptoms including memory loss, confusion, mood changes and difficulty with day-to-day tasks. Cognitive impairment is when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe.

We looked at the care of people with dementia and cognitive impairment in all of the inspections we carried out from May 2013 to July 2014. We also looked at how staff recognise and manage patients with delirium.

Areas of strength

Across the hospitals, we saw a number of staff had completed training courses in dementia, such as:

- dementia champions training programme
- staff trained in line with the Promoting Excellence framework, and
- some nursing assistants have completed out a ‘best practice in dementia’ course.

We also saw examples of trained dementia champions supporting staff to improve care, treatment and outcomes of patients with dementia. For example, working together to improve the ward environments to make sure they are dementia-friendly, such as advising on colour-contrasting and lighting in the wards.

Nine of the hospitals we inspected had a dedicated psychiatric liaison service for older people, supporting the patient’s journey. A psychiatric liaison service identifies and assesses patients when they are admitted to hospital, gives advice on treatment and follows up with

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8 Cognitive Impairment: A call for action, now! (February 2011)
9 Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers (June 2011)
these patients while they remain in hospital. The team also often liaises with the community mental health teams after a patient is discharged from hospital.

**Areas for improvement**

National guidance states that every patient aged 65 years and over is assessed for cognitive impairment when admitted to hospital.

In 12 inspections, we found that screening for cognitive impairment was not routinely carried out or recorded for patients when admitted to hospital.

We found a lack of personal care plans in place for patients with an identified cognitive impairment. This should identify the specific needs of patients and how staff will meet these needs. Documentation available for staff to use does not allow them to evidence personalised care needs or demonstrate patient choice or preferences. Care plans were often generic, pre-printed documents which were not specific to the needs of individual patients. This does not provide a clear record of the care required and given to a patient, and does not demonstrate evaluation of that patient’s care.

We also found that documents used to record key personal information about patients such as habits, background, likes and dislikes, and things that are important to them, were not completed consistently or did not reflect person-centred care approaches. Recording personal information can make a patient’s stay in hospital as positive and personal as it can be.

In all but one of the hospitals inspected, we found that current legislation, which protects the rights of patients who lack capacity, was not fully and appropriately documented and implemented. 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. This can relate to financial and property matters, personal welfare or both. When legislation is used, this must be fully documented in the patient’s health record, including any discussion with the patient or family.

We found examples of hospitals trying to improve the ward environments for patients with dementia. However, more work is required to improve the environments for people with dementia or a cognitive impairment. We found some examples of pictorial signs for toilets, but many of the hospitals had signs which were not dementia friendly, for example ‘way finding signage’. We also found that some hospitals had not followed best practice guidance to use contrasting colours to help patients with dementia find their way around the ward.

**National improvements in dementia and cognitive impairment**

The Chief Nursing Officer for Scotland is leading a programme of improvement activity with NHS boards and others, into the care of older people, including those with dementia in acute hospitals. Our inspection and improvement programmes complement this work. Scotland’s first dementia strategy was published in June 2010. It sets out the work taking place to improve support, care and treatment for people with dementia, their families and carers by focusing on improving the quality of dementia services through more timely diagnosis and on better care and treatment, particularly in hospital settings.

A second strategy, Scotland’s National Dementia Strategy 2013-2016, further strengthened this focus on improving care for people with dementia in acute hospitals with a commitment to develop and deliver a 3-year national action plan to improve care in acute hospitals.
Ten ‘headline areas’ have been identified for improving care for people with dementia in acute hospitals. Each NHS board has to submit an action plan to the Scottish Government detailing how they are addressing these areas. The Scottish Government has developed a national improvement programme to support NHS boards in this work and, in particular, the following two headline areas:

- working with families, friends and carers as equal partners, and
- minimising and responding appropriately to stress and distress.

In 2011, the Standards of Care for Dementia in Scotland were published as well as the *Promoting Excellence* framework, which supports the health and social services workforce to meet the standards.

**Improvement highlight...**

**NHS Ayrshire & Arran**

We continue to build and improve on clinical practice in relation to frailty, delirium and dementia. Frailty and delirium pathway pilots have been carried out in three test areas in University Hospitals Ayr and Crosshouse. Further roll-out of both pathways is now due to begin. As part of these pathways, all patients over the age of 65 years admitted through emergency departments in both hospitals are now assessed using the 4AT (a cognitive impairment screening tool). Use of signifiers, such as visual cues for staff, which indicate cognitive deficits are now standard practice throughout the NHS board.

Learning events have been held across the NHS board, including training days, workshops, posters, mentoring and support. Over 5,000 staff have attended training in dementia across the four levels of the *Promoting Excellence* framework. In collaboration with Alliance Scotland, Tommy Whitelaw, who has been a full-time carer for his mother, delivered a series of workshops throughout the NHS board. These focus on the carer’s perspective. Currently, 424 staff have attended the talks (nurses, allied health professionals, medics, students, administration and support staff, social work, fire and rescue and police colleagues).

As an improvement measure, we have now combined adults with incapacity certificate and treatment plan documents into a single document. This has been spread throughout all clinical areas and has shown early positive outcomes. Ward huddles and safety briefs have been used to re-emphasise completion of the document. We are currently training senior nursing staff to be able to complete the adults with incapacity certification.
Improvement highlight...

NHS Fife
Our commitment to improving care of older people in acute hospitals can be evidenced through the work of the ‘inspection co-ordinating group’. The remit of this group is to oversee workstreams involved in the care of older people, scrutinise improvement activity and ensure that national and local standards are achieved and sustained. The group, which meets on a fortnightly basis, is attended by the director of acute services, the associate medical director and director of nursing (acute services), general managers, heads of nursing, allied health professional (AHP) heads of service, estates and facilities managers.

Adults with incapacity
New adult with incapacity documentation has been developed and introduced in Victoria Hospital, Kirkcaldy. An assessment of capacity is now documented in 100% of patients with an adults with incapacity form (results from July 2014 audit). Previously, performance on this was close to 0%. Further audits in Victoria Hospital are planned, and discussion is under way about extending the audit across NHS Fife.

The new documentation has helped to drive improvement in the discussion and completion of treatment plans. The most recent adults with incapacity audit in Victoria Hospital (August 2014) demonstrated that 89% of patients identified as not having capacity had treatment plans in place.

Improvement highlight...

NHS Grampian
Our department of medicine for the elderly’s vision is to promote health, well-being and independence amongst all older people with frailty living within Grampian. Much was achieved in acute care as part of the ‘older people in acute care collaborative’ that we carried out in partnership with NHS Tayside. Work has continued on from the collaborative and key areas include the following.

- Patients identified as frail (using Healthcare Improvement Scotland’s ‘Think Frailty’ tool) are directed to the geriatric assessment unit. This is now embedded in practice and working well.

- These patients are able to consistently access comprehensive geriatric assessment within 24 hours of admission, 7 days a week.

- Work continues around improving delirium identification and management within the orthopaedics and emergency department.

- The multidisciplinary team has set up a quality improvement group providing leadership, education and support to progress a quality improvement agenda. Initial priority areas identified for improvement work within the department are falls, delirium, admission/assessment and effective discharges. The team is using the collaborative approach to learning and sharing to progress its work in these areas.
Improvement highlight...

NHS Greater Glasgow and Clyde

Following a recent older people inspection to one of our acute hospitals, clinical staff approached Healthcare Improvement Scotland’s older people in acute care improvement team to assist them in planning improvement activity within their older people wards. Healthcare Improvement Scotland assisted our staff to shape and test an exemplar ward project.

Healthcare Improvement Scotland brought together multiple strands of our organisation’s work to support the improvement needs of teams working in older people’s services in NHS Greater Glasgow and Clyde. The idea behind the exemplar ward testing is to innovate with frontline teams to create a blended approach to best care for older people. The catalyst for this work was scrutiny - the inspection gave real insight into the opportunities for improvement.

We then set about drawing together individuals from all of the separate national strands relevant to this care context:

- older people in acute hospitals (frailty/delirium)
- falls
- person-centred care
- dementia, and
- scrutiny.

We also built in an improvement skills workshop at the start of the improvement day.

- The day was then structured as a single ‘improvement workshop’ that focused on the ‘how’ and the ‘what’ for all the key pieces of work relevant to this care context.
- The result of this for the clinicians attending was that it felt like a single joined-up approach rather than four or five ‘programmes’.
- The local team is now seeking to organise themselves as an ‘exemplar ward’.

Progress to date

Healthcare Improvement Scotland is now supporting the exemplar work at the Southern General Hospital, Glasgow. The older people in acute hospitals and person-centred care workstreams will take the lead on any communication and direct support on the ground with teams.

- Exemplar wards are focusing on the overall reduction of falls. Teams have taken part in an environmental walkround to risk assess areas for risk to their patients. As a result, care bundles have been created aligning to the Scottish Patient Safety Indicator. They have also recognised that, in their ward areas, very high percentages of their client group are at high risk for falls. Therefore, all patients are risk assessed on arrival.
- Teams have naturally weaved in the importance of delirium care into this area. Wards are now testing the 4AT to detect delirium on arrival.
- Teams are creating a prototype of a true person-centred care plan to truly keep the person at the centre of all we do by using the ‘What’s important to me’ approach.
- Testing of the 4AT and delirium care bundle is in progress. The elderly care nurses are now following up every person with a delirium diagnosis two weeks post admission with a phone call to support families and check on progress.
Improvement highlight...

NHS Lothian

Our interest in frailty is part of the NHS board’s overall delivering better care programme to improve the quality, safety and effectiveness of patient care and patient experience. We were asked to become a test site for frailty as a result of Healthcare Improvement Scotland’s national initiative on improving the identification, assessment and treatment of frailty and delirium. We carried out our initial testing using improvement methodology (plan, do, study, act [PDSA] cycles) and implemented this within one of the surgical wards. We have now commenced measurement and recording of our data using the skills of our surgical elderly care assessment team (SECAT). Our findings in the test phase at the surgical services test site showed an increase in frailty screening from 30% to 90.9%, a significant improvement.

The Delivering Better Care Hub continues to support our SECAT nurses. As a result of this work, we are able to demonstrate that there has been a reduction in length of patient stay by 2 days for frail surgical patients. Readmissions have been reduced and complaints have decreased. This is a result of education, increased knowledge and support to the clinical team. Staff are motivated in the clinical test area and continue to move this forward.

Due to the success of this pilot, we have replicated frailty identification, assessment and treatment of frailty in the Western General Hospital, Edinburgh. We are also about to commence this at St John’s Hospital, Livingston. Other areas within NHS Lothian are keen to utilise the success of our testing and implement screening in their areas.

The key factors enabling the project’s success and recommendations for other sites are:

- plan thoroughly, including the membership of the project team
- provide information to staff in advance of starting a project so that they have time to become familiar with it before they begin
- keep things simple and make the tools easy to use
- involve staff in all aspects of the improvement work, and
- giving people factual information about the project’s progress creates a ‘positive feedback loop’ which builds enthusiasm and a sense of ownership of the project.
Improvement highlight...

NHS Tayside
For the last 10 months, our older people board and older people joint clinical forum have been working on three priority areas of care:

- dementia
- frailty, and
- delirium.

Some of this work had started through the older people in acute care collaborative improvement project between ourselves and NHS Grampian.

We organised a successful ‘delirium awareness week’ in March 2014. This had a positive impact on staff giving them confidence in recognising and managing delirium in the acute setting. We are capitalising on devoted clinicians to drive this agenda both locally and nationally. We have appointed a practice development delirium nurse. We believe this post to be a first in Scotland and will drive forward improvement in the detection and management of delirium. This position will link closely with the consultant nurses for dementia and older people. The development of screening tools and the embedding of these tools in practice is a priority.

This includes the 4AT and single questions in care rounds and multidisciplinary team documentation to identify delirium. Comprehensive geriatric assessment, including the 4AT, is completed in our medical receiving unit in Ninewells Hospital, Dundee. We are developing the treatment pathway alongside NHS Tayside’s delirium guidelines. This is currently happening within acute settings. However, we recognise the need for a complete review service-wide, so links are already being made to district nursing teams, community hospitals and care home teams.

Education is a big part of this initiative and the NHS Education for Scotland (NES) delirium module was completed with input from our clinical staff and patients. This is now available on LearnPro (an online training and education system) to complement face-to-face teaching. We have also just launched our capacity and consent LearnPro module, which is clearly linked to this improvement work.

3.4 Nutritional care and hydration

Nutritional care and hydration relates to the provision of food and fluid or nutritional support to patients. Effective multidisciplinary team working is needed to ensure the individual dietary needs of all patients are met. Older people are more likely to be undernourished when admitted to hospital and remain undernourished during their hospital stay. Therefore, the majority of patients depend on hospital food to improve or maintain their nutritional state in order to optimise their recovery from illness.

We looked at nutritional care and hydration in 14 of the 15 inspections we carried out from May 2013 to July 2014.

Areas of strength
In some hospitals inspected, we found good working relationships between ward staff and kitchen staff in relation to meeting individual patients’ dietary needs. We also saw good
multidisciplinary input from dietitians and speech and language therapists when patients had been referred.

We also saw mealtime co-ordinators on some wards. They help to establish a more organised approach to managing mealtimes. They were responsible for making sure that mealtimes were well managed and that ward staff helped patients prepare for their meal. They also helped patients with eating and drinking when needed. We saw good examples of staff encouraging patients to eat at mealtimes.

We also saw a few good examples of patient nutrition boards. These identify individual patient dietary needs, such as patients who are taking nutritional supplements or who are on a special diet.

**Areas for improvement**

In the majority of hospitals inspected, we found inconsistent approaches to nutritional screening and the use of personalised nutritional care plans. All hospitals use the Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. The tool includes:

- information on a patient’s height and current weight
- the patient’s body mass index (BMI)
- any unplanned weight loss, and
- whether the patient is acutely ill and there has been or is likely to be no nutritional intake for more than 5 days.

In all hospitals inspected, we found that nutritional screening was not always done within 24 hours of admission. It was also not always clear if patients’ weights and heights were accurately measured using weighing scales, were reported by the patient themselves or were estimated by staff. Screening results were often not documented.

Nutritional assessments also need to be completed for each patient on admission to hospital. This is to identify individual needs such as allergies, eating and drinking likes and dislikes, and whether help or equipment is needed at mealtimes. We found that these were not always fully completed and did not always inform a patient’s care plan.

Re-screening patients for their risk of malnutrition should be carried out on a weekly basis. However, in the majority of hospitals inspected, we found that this was not done.

We found that personalised nutritional care plans were not always completed or updated to reflect changes in a patient’s condition. We also found there was not always clear medical or nursing care plans for patients with complex nutritional care needs, for example some patients can have difficulty in swallowing food and drink. Care plans are necessary in guiding ward staff on how best to meet an individual patient’s nutritional care needs. This is particularly important when a person has a cognitive impairment, is at risk of developing pressure ulcers or has a communication difficulty.

We also found that patients’ intake of food and fluid was not always being accurately recorded. This can impact on the appropriate treatment and care being provided to patients.

We saw an inconsistent approach to clearly identifying patients who needed modified consistency diet and fluids, or who were on a special diet and communicating this to relevant ward staff. This increases the risk for these patients of not receiving the correct diet and fluids, for which they have been assessed.
Protected mealtimes make sure that eating and drinking are the focus for patients without unnecessary distractions and that patients who need help to eat and drink get the help they need. In some of our inspections, we found good examples of protected mealtimes being adhered to. However, in 10 of the hospitals inspected we found that mealtimes were interrupted by non-essential activity such as delivering personal care when meals were being served, carrying out routine blood pressure checks and bed making.

We saw inconsistent approaches to identifying patients who required help at mealtimes, with some NHS boards having different systems in place within the same hospital.

If a patient had missed their meal, for example if they were away from the ward getting a test, we found that hot meal replacements were not always available. Snacks were not always provided to patients outwith mealtimes, meaning there could be a long time between meals, for example between evening meal and breakfast.

Patient comments
Patients we spoke with were mainly complimentary about the food and drinks provided in hospital, for example:

- “I arrived [to the ward] late but still had a choice of meals.”
- “Good food indeed, plenty of choice. Always hot, never cold.”

However, occasionally patients told us about concerns they had relating to nutritional care, for example:

- “My daughter in law needed to make staff aware that I needed assistance at mealtimes.”
- “I have a food allergy to wheat and milk products. The present system does not allow me much discretion as the food comes pre packed for heating.”

National improvements in nutritional care for patients
Nutritional care is reported nationally through the clinical quality indicator for food, fluid and nutritional care. This is part of the Leading Better Care national programme which supports implementation of a national role framework and clinical quality indicators for nursing and midwifery staff across NHSScotland.

There is also a nutritional care element within the ‘SSKIN’ care bundle (surface, skin, keep moving, incontinence, nutrition) as part of the national Scottish Patient Safety Programme’s prevention of pressure ulcers change package. Some of the nutritional elements relate to offering patients a drink and providing assistance with a meal, if required. NHS boards have been testing and implementing the SSKIN care bundle since its introduction through Leading Better Care in 2011. This work was integrated with the Scottish Patient Safety Programme in 2013 with data on process and outcome now reported through this route.

Review of food, fluid and nutritional care standards
In 2014, we started work to update the NHS Quality Improvement Scotland Clinical Standards for Food, Fluid and Nutritional Care in Hospitals (September 2003). These are the standards that we currently measure NHS boards against when we focus on nutritional care and hydration during our inspections. The Scottish Government has asked us to extend the scope to include community as well as acute care. The National Nutritional Care Advisory Board is providing specialist input and clinical assurance into the review of these standards.

10 [www.leadingbettercare.scot.nhs.uk](http://www.leadingbettercare.scot.nhs.uk)
A wide consultation on the draft standards took place during June–July 2014. This involved seeking comments from NHS colleagues, Scottish Government, Royal Colleges, relevant professional organisations and the voluntary sector. We published the standards for food, fluid and nutrition in October 2014.

The National Nutritional Care Advisory Board is developing nutritional care measures based on the revised standards. These measurements check that patients are receiving the appropriate nutritional care to meet their needs.

### Improvement highlight...

**NHS Fife**

We have identified improving hydration and fluid management as a priority for improvement. This initiative is being led by the quality improvement nurse and a consultant anaesthetist. Guidance from the National Institute for Health and Care Excellence (NICE) on intravenous fluid therapy in adults in hospital (2013) recommends a daily fluid intake of 25–30ml/kg/24hrs. Our aim is to achieve 95% of patients with a documented fluid intake of ≥75% of 30ml/kg/24hrs. New fluid management documentation comprises a combined fluid prescription and fluid balance chart. This standardised chart has allowed unification of start and stop times for fluid balance charts, and has contributed to improvement in transitions in care. Audit has shown improvement from 20% to 80% in Victoria Hospital, Kirkcaldy. Work continues to maintain this improvement and achieve our stated aim.

#### 3.5 Prevention and management of pressure ulcers

Pressure ulcers are areas of tissue damage that occur in people who cannot reposition themselves, the acutely ill, the older person, and the malnourished. Pressure ulcers negatively affect quality of life and can cause significant harm to patients.

We looked at the prevention and management of pressure ulcers in 12 of the 15 inspections for the care of older people in hospitals we carried out from May 2013 to July 2014.

**Areas of strength**

We found that the majority of hospitals had a good supply of specialist pressure relieving equipment, such as specialist mattresses for patients who had been identified as at an increased risk of developing a pressure ulcer. Most staff were able to explain how equipment was obtained and were confident that these items were readily available at all times. During our inspections, we saw many examples of appropriate specialist equipment in use.

In the majority of hospitals inspected, we found that tissue viability services were available to provide support, advice and information to staff on preventing and managing pressure ulcers to improve the care of patients. Most staff were aware of how to access the service and described the positive working relationship they had with the service.

**Areas for improvement**

The majority of hospitals inspected are using an adapted 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 to hospital. During our inspections, we found that not all risk assessments had been carried out within this timeframe.
Where initial assessments had been carried out, we found little evidence of regular reassessment where risks had been identified. We also found instances where scores had been calculated incorrectly. This may lead to the incorrect level of risk being identified and inappropriate interventions taking place.

The outcome of the Waterlow risk assessment should inform the frequency of the skin care bundle. All hospitals inspected were using the SSKIN care bundle. However, across the hospitals inspected, we found little evidence of personalised care planning being used to help prevent and manage pressure ulcers.

We found that wound assessment charts were not consistently in place for patients with pressure ulcers. Where the charts were in place, these were not consistently completed.

**National improvements in the prevention and management of pressure ulcers**

The Scottish patient safety indicator was developed in 2013 to provide a person-centred approach to harm reduction by aiming to reduce the number of people experiencing any of the identified four key harms from acute care. Pressure ulcers are one of the four key harms measured.

This combines the existing work of Leading Better Care on pressure ulcers with the work of the Scottish Patient Safety Programme to improve reliable delivery of risk assessment, reassessment and evidence-based interventions to reduce the likelihood of skin damage.

The acute adult safety team is working with leadership, improvement and clinical teams in NHSScotland to understand existing levels of the specified harms and implement evidence-based processes that will improve outcomes for patients.

**Improvement highlight...**

**NHS Forth Valley**

Since 2010, a range of actions have been taken forward to reduce and prevent pressure ulcer incidence across both inpatient areas and in the community. These actions have resulted in a continued reduction in the incidence of pressure ulcers through work carried out as part of the clinical quality indicator. The clinical quality indicator for pressure area care is one of a range of measures that NHS boards collect data on. This includes whether a pressure ulcer risk assessment has been carried out, compliance with SSKIN bundles, preventative measures put in place and positioning of patients at risk of developing a pressure ulcer. Actions from the clinical quality indicator have included:

- implementation of the Braden risk assessment tool
- use of the pressure ulcer safety cross
- refinement of the incident reporting system to understand the cause of the incident, and
- other actions from the ‘Assuring Better Care’ campaign.

An established data collection system is now in place and forms part of the senior charge nurse balanced scorecard. This information is reviewed and actioned by the individual nursing team. This is then shared at the senior charge nurse quality improvement meeting where there is a collective review and learning from the incident.

The compliance rate for the clinical quality indicator is 95% and above. Once 95% compliance is achieved it is recognised that the NHS board has reliable processes in place. NHS Forth Valley’s current performance of the clinical quality indicator for pressure ulcers remains above 95%. This work has been presented at a recent national Scottish Patient Safety Learning Session.
4 Our recommendations

While we have seen increased awareness of the issues facing older people in hospitals, we make similar recommendations for NHS boards as in our previous overview reports.

NHS boards in Scotland should:

- ensure record-keeping including assessments, care plans and evaluations, which were found to be poor across all the themes inspected, are carried out to national and professional guidelines
- ensure that all NHS frontline staff are aware of the legislative requirements, and their application, that affect those patients with a cognitive impairment, in particular adults with incapacity
- ensure that DNACPR guidelines are fully implemented
- continue to develop the role of the dementia champions and promote more access to these training programmes, particularly for allied health professionals, and
- continue to actively engage with improvement programmes for older people, safety and person-centred care to make sure teams are aware of best practice and receive support to build capacity and capability for improvement.

4.1 Next steps

Review of standards for older people in acute care

We are currently revising the Clinical Standards for Older People in Acute Care (October 2002). These are the standards that we currently measure NHS boards against as well as a range of other standards, best practice statements and other national documents relevant to the care of older people in acute hospitals.

The project group includes lay representatives, inspectors and representatives from medical, nursing, allied health professionals and other agencies involved in the care of older people (for example Age Concern, Alzheimer’s Scotland). The draft standards have also been shared with the group chaired by Pam Whittle, CBE, which reviewed our older people’s inspection methodology.

The draft standards will be issued for consultation in November 2014. The revised standards will be published in March 2015.
### Appendix 1 – Hospitals we inspected

<table>
<thead>
<tr>
<th>Inspection</th>
<th>Type of inspection</th>
<th>Date of inspection</th>
<th>Report and action plan published</th>
</tr>
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<tbody>
<tr>
<td>Victoria Hospital NHS Fife</td>
<td>Announced</td>
<td>14-16 May 2013</td>
<td>8 July 2013</td>
</tr>
<tr>
<td>University Hospital Crosshouse NHS Ayrshire &amp; Arran</td>
<td>Announced</td>
<td>11-13 June 2013</td>
<td>7 August 2013</td>
</tr>
<tr>
<td>Forth Valley Royal Hospital NHS Forth Valley</td>
<td>Announced</td>
<td>23-25 July 2013</td>
<td>18 September 2013</td>
</tr>
<tr>
<td>St John’s Hospital NHS Lothian</td>
<td>Unannounced</td>
<td>3-5 September 2013</td>
<td>28 October 2013</td>
</tr>
<tr>
<td>Raigmore Hospital NHS Highland</td>
<td>Announced</td>
<td>24-26 September 2013</td>
<td>19 November 2013</td>
</tr>
<tr>
<td>Balfour Hospital NHS Orkney</td>
<td>Announced</td>
<td>15-17 October 2013</td>
<td>10 December 2013</td>
</tr>
<tr>
<td>Gartnavel General Hospital NHS Greater Glasgow and Clyde</td>
<td>Unannounced</td>
<td>29-31 October 2013</td>
<td>8 January 2014</td>
</tr>
<tr>
<td>Dr Gray’s Hospital NHS Grampian</td>
<td>Unannounced</td>
<td>19-20 November 2013</td>
<td>27 January 2014</td>
</tr>
<tr>
<td>Victoria Hospital NHS Fife (follow-up)</td>
<td>Unannounced</td>
<td>15-17 December 2013</td>
<td>11 March 2014</td>
</tr>
<tr>
<td>Southern General Hospital NHS Greater Glasgow and Clyde</td>
<td>Unannounced</td>
<td>18-20 February 2014</td>
<td>30 April 2014</td>
</tr>
<tr>
<td>Gilbert Bain Hospital NHS Shetland</td>
<td>Announced</td>
<td>27-28 March 2014</td>
<td>5 June 2014</td>
</tr>
<tr>
<td>Balfour Hospital NHS Orkney (follow-up)</td>
<td>Unannounced</td>
<td>7-9 April 2014</td>
<td>2 June 2014</td>
</tr>
<tr>
<td>Victoria Infirmary NHS Greater Glasgow and Clyde</td>
<td>Unannounced</td>
<td>22-24 April 2014 (and 19 May 2014)</td>
<td>24 June 2014</td>
</tr>
<tr>
<td>University Hospital Ayr NHS Ayrshire &amp; Arran</td>
<td>Unannounced</td>
<td>27-29 May 2014</td>
<td>29 July 2014</td>
</tr>
</tbody>
</table>
Appendix 2 – Inspection process

Before our inspections

Our inspection process starts by prioritising acute hospitals against a range of indicators. We then create a programme of inspections for the upcoming year. We ask all NHS boards to complete a self-assessment which allows them to establish their own performance against the key issues and to start proactive improvement work. The information in the self-assessment also allows us to identify the key areas to focus on during inspections. We also gather information about each hospital from other sources. This includes Scotland’s Patient Experience Programme and other data that relate to the care of older people.

We then carry out an inspection to a hospital to confirm the information in the NHS board’s self-assessment. We carry out both announced and unannounced inspections. We give NHS boards 4 weeks’ notice of an announced inspection, while no notice is given for an unannounced inspection. Announced inspections allow us to meet with senior members of staff to find out what should be happening within the hospital. Unannounced inspections lessen the stresses and anxiety felt by staff and reduce the extra work involved for staff in preparing for an inspection.

During our inspections

During our inspection, we check that the policies and procedures are being put into practice for patients and gather evidence on performance and risk. As well as speaking to staff and patients, we also observe interactions between staff and patients. Ensuring that older people are treated with compassion, dignity and respect is a focus on all our inspections.

Our inspections typically last 2–3 days and only cover a sample of wards, so they provide a snapshot of what is happening in the hospital. We also review patient health records to check that:

- assessments are being completed
- care plans are being developed and
- appropriate patient care is provided.

Following our inspections

Following our inspection, we publish an inspection report based on our findings, approximately 8 weeks after the inspection has taken place. NHS boards then develop an improvement action plan to address the areas we identified for improvement and we monitor progress against this.

Approximately 16 weeks after the inspection has taken place, we ask NHS boards to submit an updated improvement action plan to show what improvements they have made.

If it is appropriate, we will carry out a follow-up inspection to that hospital to check on improvements. As we continue to carry out more inspections, we will revisit the hospitals we have already inspected to make sure that we inspect all topics in all NHS boards.
Appendix 3 – Inspection process flow chart

This process is the same for both announced and unannounced inspections.

```
Before inspection
- Self-assessment framework finalised and issued
- NHS board undertakes self-assessment exercise and submits outcomes to Healthcare Improvement Scotland
- Healthcare Improvement Scotland reviews self-assessment submission to inform and prepare on-site inspections

During inspection
- Arrive at hospital
- Inspections of selected wards and departments
- Individual discussions with senior staff or operational staff, or both, and patients
- Group discussions with NHS board and senior hospital staff
- Feedback with NHS board and senior hospital staff
- Further inspection of hospital if areas of significant concern identified

After inspection
- Report and improvement action plan published
- Follow-up activity to ensure improvement actions are completed
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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.

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

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