Unannounced Inspection Report – Care of Older People in Acute Hospitals

St John’s Hospital
NHS Lothian

31 July—2 August 2018
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Background

1. 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 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 Care of Older People in Hospital Standards (Healthcare Improvement Scotland, June 2015).

2. Our inspections focus on the three national quality ambitions for NHSScotland, which aim to ensure that all care is person-centred, safe and effective. The process includes a planned NHS board visit which allows them to highlight areas of good practice and also areas where improvements could be made. We follow up the NHS board visits with an inspection to each acute hospital in the NHS board area.

3. We are working closely with improvement colleagues in Healthcare Improvement Scotland to ensure that we appropriately support NHS board teams to deliver improvements locally and to share and learn from others.

4. During our inspection, we identify areas where NHS boards:
   - **must take action in a particular area**: If we tell an NHS board that it must take action, this means the improvements we have identified are linked to national standards, other national guidance and best practice in healthcare. A list of relevant national standards, guidance and best practice can be found in Appendix 3.
   - **should take action in a particular area**: If we tell an NHS board that it should take action, this means that although the improvements are not directly linked to national standards, guidance or best practice, we consider the care that patients receive would be improved.

About this report

5. This report sets out the findings from our unannounced inspection to St John’s Hospital, NHS Lothian. The report highlights two areas of good practice and eight areas for improvement.

6. The team was made up of three inspectors and a public partner, with support from a project officer. An inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached.
7. The flow chart in Appendix 4 summarises our inspection process. More information about Healthcare Improvement Scotland, our inspections, methodology and inspection tools can be found at www.healthcareimprovementscotland.org/OPAH.
A summary of our inspection

8. St John’s Hospital, Livingston serves the Lothian area. It has 409 beds and provides a full range of healthcare specialties.

9. We carried out an unannounced inspection to St John’s Hospital from Tuesday 31 July to Thursday 2 August 2018 and we inspected the following areas:
   - medical admissions unit
   - ward 4 (stroke rehabilitation)
   - ward 8 (medicine for the elderly), and
   - ward 14 (orthopaedic medicine).

10. Before the inspection, we reviewed NHS Lothian’s self-evaluation and gathered information about St John’s Hospital from other sources. This included Scotland’s Patient Experience Programme and other data that relate to the care of older people. Based on our review of this information, we focused the inspection on the following outcomes:
   - treating older people with compassion, dignity and respect
   - screening and initial assessment for frailty, nutritional care and falls, pressure ulcers
   - person-centred care planning
   - food, fluid and nutrition
   - falls
   - pressure area care
   - care transitions
   - skills and accountability, and
   - communication.

11. During the inspection, we:
   - spoke with staff and used additional tools to gather more information. We carried out five periods of observation using a formal observation tool and a mealtime observation tool. In each instance, members of our team observed interactions between patients and members of staff.
   - carried out patient interviews and used patient and carer questionnaires. A key part of the public partner role is to talk with patients about their experience of staying in hospital and listen to what is important to them. We spoke with 17 patients and one relative during
this inspection. We received completed questionnaires from 31 patients and 13 family members, carers or friends.

- reviewed 13 patient health records to check the care we observed was as described in the care plans. We reviewed all patient health records for food, fluid and nutrition, falls, and pressure ulcer care. We also reviewed the patient health records for do not attempt cardiopulmonary resuscitation forms.

12. We would like to thank NHS Lothian and in particular all staff at St John’s Hospital for their assistance during the inspection.

Key messages

13. We noted areas where NHS Lothian is performing well and also areas for improvement, including the following.

- All wards had access to a supply of non-slip socks for patients who did not have appropriate footwear.
- Proactive discharge planning.
- Lack of detailed care planning.
- The electronic patient health record system in place must be improved to ensure accurate and accessible patient health records. We were unable to report the number of patient assessments correctly completed within the nationally required time frames and we were unable to see whether patient outcomes were improving or not. Due to the system only logging the date and time of previous changes, it is not possible to see the outcome and dates of the original assessments.

What action we expect the NHS board to take after our inspection

14. This inspection resulted in two areas of good practice and eight areas for improvement. A full list of the areas of good practice and areas for improvement can be found in Appendices 1 and 2, respectively on pages 28 and 29. We expect NHS Lothian to address all the areas for improvement. The NHS board must prioritise those areas where improvement is required to meet a national standard.

15. The NHS board has developed an improvement action plan, which is available to view on the Healthcare Improvement Scotland website (www.healthcareimprovementscotland.org/OPAH) and the NHS board website for 16 weeks. After this time, the action plan can be requested from Healthcare Improvement Scotland.
What we found during this inspection

Treating older people with compassion, dignity and respect

16. During our inspection, we saw all staff treating patients with dignity and respect. All patients appeared well cared for and comfortable, and the majority of patients were dressed in their own clothes.

17. We observed that patients had drinks and personal items within reach, including glasses and hearing aids. In some wards, we saw that patients were not always able to reach their walking aids. For example, we saw a walking aid at the end of a patient’s bed where they could not reach it from their chair.

18. We saw that patients had call bells within reach. Staff were visible in patient areas and, when call bells were heard, staff responded promptly.

19. We saw staff maintained patients’ privacy by closing doors or bedside curtains when delivering care.

Patient and staff interactions

20. Staff worked as a team and communicated well to ensure care was organised. Interactions we observed between staff and patients were positive. No negative or inappropriate language was heard. We observed staff addressing patients by their preferred name and introducing themselves if they were not already known to the patient.

21. On some wards, patients told our public partner that staff went the extra mile for them. For example, we were told about staff celebrating a patient birthday, allowing a pet to visit and facilitating visits away from the ward area.

Meaningful activity

22. Activities which encourage patients to socialise while they are in hospital can help them stay active and maintain their current levels of physical and mental functioning.

23. We saw one ward had a small sitting room that was used for a weekly afternoon tea and other themed events. In another ward, staff told us they were planning to purchase a dining table so that patients could eat meals together in a day room.

24. Staff told us that there were limited opportunities to provide activities to keep patients occupied during the day. They felt that this was especially important for those patients who had been in hospital for a long time, for example patients receiving rehabilitation or patients waiting for a home care package. Staff in one ward felt that they would benefit from an activities co-ordinator role so that protected time could be given to providing meaningful activities.
General environment

25. We saw that wards appeared calm despite being busy during our inspection. The majority of the wards we inspected were bright and fresh smelling.

26. Patients were cared for in either single sex bays or single rooms with the exception of the medical admissions unit. Due to the emergency admissions on the day we inspected this unit, it was necessary to have a mixed sex bay. While this is appropriate in an emergency ward, we saw that patients were moved to create single sex bays as beds became available.

27. All rooms had ensuite toilet facilities. All patients had access to shower facilities either in the ward area or within their room. One ward had a bath available for patients. Dementia design principles were used for signage on toilets, shower rooms, bathrooms and bedrooms.

28. Wards all had equipment stored in the corridors but it was generally stored to one side to maintain a clear walkway.

Display of patient information

29. In some wards we saw a whiteboard in the ward corridor which was visible to visitors. It showed information about named individual patients who were receiving care from the physiotherapist and occupational therapist. The information was about goal setting, who required a case conference and any other messages to be communicated. This did not maintain patient privacy.

30. We saw that patient information displayed on bedside boards was minimal and risk based, for example the patient’s name, preferred name, and nutritional and mobility information. Some boards included a place for ‘What matters to me’ but these were often blank.

Patient and carer feedback

31. During our inspection, we spoke with 17 patients and one relative. Through discussions with our public partner, patients were able to give their opinions about the care they received while in hospital. Feedback from patients on their care received included the following:

- ‘The staff are outstanding with the older patients. The way they talk to them makes me feel good. So good and nothing a bother’.
- ‘Staff friendly and approachable day and night’.

32. We received 31 completed patient questionnaires. Of the 31 patients who completed the questionnaire, we received the following responses to pre-set statements:
• 24 patients agreed or strongly agreed that ‘I get help with eating and drinking if I need it.’
• 28 patients agreed or strongly agreed that ‘I have discussions with staff about my care and treatment.’
• 28 patients agreed or strongly agreed that ‘Staff always introduce themselves.’

33. Patients also commented that:
• ‘Staff are very cheerful and obliging.’
• ‘Staff are very friendly and always calling me by my first name.’

34. We received 13 completed questionnaires from carers and visitors. Of the 13 carers and visitors who completed the questionnaire, we received the following responses to pre-set statements:
• six visitors agreed or strongly agreed that ‘I feel as involved in the care and treatment of the person I am visiting as I would like to be.’
• ten visitors agreed or strongly agreed that ‘I know who to speak to if I have questions about the care and treatment of the person I am visiting.’
• 11 visitors agreed or strongly agreed that ‘Staff are friendly and approachable.’

35. Carers and visitors also commented that:
• ‘The care she is receiving is great, my mother especially enjoys the Sunday get together with carers.’
• ‘In my experience it is virtually impossible to get any information as to what is wrong with my mum or even basic information regarding treatment.’

Area for improvement

1. NHS Lothian should ensure that patient identifiable information, such as risk alerts and care needs details, are not on public display. This will ensure that patient privacy and dignity is respected.

Outcome 1: Screening and initial assessment

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.

36. All older people admitted to hospital should have assessments carried out to identify any risks and care needs. This should include assessments of frailty, nutritional state, risk of falls and risk of developing pressure ulcers. Information gathered to complete the assessments should be accurately recorded and should indicate the date and time these assessments were undertaken. The accuracy of assessments and, where appropriate, the source of information is important as this can impact on other assessments and aspects of care. For example, accurate height and weight are required for both nutrition and pressure ulcer risk assessments.

Electronic patient health record system

37. Following our previous inspections to the Royal Infirmary of Edinburgh in August–September 2016 and the Western General Hospital in August 2017, we reported issues with NHS Lothian’s electronic patient health record system. We reported issues accessing:

- the patients’ initial assessment and screenings, including food, fluid and nutrition and pressure area care, to see if they had been accurately completed on admission, and
- the previous dates of patient assessments and outcomes, dates of reassessments due and individual measurements, such as heights and weights.

38. During our inspection of St John’s Hospital, we experienced similar issues accessing information on the system. All the staff we interviewed stated that they had received training on the use of the electronic patient health record system. Staff were aware of how to use the system and demonstrated that they could navigate through the various pages available.

39. Due to the system only recording the time and date of previous changes made, we were not always able to see the dates and outcomes of original assessments.

40. Due to the system’s constraints, we were unable to find out how many patient assessments had been correctly completed within the nationally required time frames. We were also unable to see whether patient outcomes were improving or not.
41. We were told that in the medical admissions unit some patients’ initial assessments are being recorded on paper documents as agency staff cannot access the electronic system. The first electronic entry is a reassessment by a member of staff with access to the system. This is a duplication of assessment for the patient. We are aware that NHS Lothian hopes that its ongoing recruitment work will lead to a reduction in the use of agency staff.

42. We noted that NHS Lothian’s audit tools only prompt staff to record if an assessment has been recorded. The tools do not request any further information about time frames or if the assessment is accurate. Therefore, we were unclear how NHS Lothian is able to monitor that patients are being screened and risk assessed within recognised time frames in order to assure themselves of appropriate care being delivered.

Frailty and comprehensive geriatric assessment

43. NHS Lothian’s most recent self-evaluation states that the rapid elderly assessment of care in hospital (REACH) team perform frailty screening assessments and, if required, complete comprehensive geriatric assessments. Medical staff in the medical admissions unit told us that this is a valued service as the information provided is used to inform the ward rounds.

44. We were told that the REACH team work closely with the rapid elderly assessment care team (REACT) to support early discharge. REACT provides home-based comprehensive geriatric and inter-agency assessment and acute care as an alternative to hospital admission for adults over the age of 75. REACT is carrying out some pilot work in the emergency department to promote early discharge. During our inspection, we did not see any evidence of input from REACT in the patient health records reviewed.

45. Of the 13 patient health records reviewed, one patient had a frailty screening and comprehensive geriatric assessment completed. This patient was reviewed by the elderly care assessment nurse. There was good documentation in the patient’s health record and the patient’s care was discussed with the medicine for the elderly team.

Nutritional care and hydration

46. Nutritional screening is carried out using the Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. Healthcare Improvement Scotland’s Food, Fluid and Nutritional Care Standards (2014) state: ‘The nutritional care assessment should accurately identify and record measured height and weight, with the date and time that these measurements were taken (if estimates are used, this should be stated and a rationale provided).’ It is also important to have an accurate weight recorded as it may be required for other assessments or to calculate the dosage for certain drugs.
47. We reviewed 13 patient health records for nutritional care and hydration assessments. All patients had a MUST screening completed. We saw the following:

- one patient’s MUST screening was not completed on admission to another NHS Lothian hospital, however it was completed at transfer to St John’s Hospital
- the majority of patients did not have their usual weight recorded, therefore it was unclear how their MUST scores were calculated, and
- several patients had missing information such as height, method of measurements and/or MUST scores.

**MUST rescreening**

48. MUST rescreening should take place weekly while the patient remains in hospital. It is also important that rescreening takes place so that any weight loss or gain is identified and appropriate action taken such as referral to a dietitian.

49. Of the 13 patient health records reviewed, seven patients were eligible for rescreening of MUST. The majority of patients had this carried out, however it was not possible to see previous MUST scores and how they were calculated. We could not be assured of the accuracy of MUST information due to the constraints of the electronic system. We also saw the following.

- Some patients had their height and weight recorded, and Body Mass Index (BMI) calculated but the constraints of the system meant that we could not view the resulting MUST scores.
- One patient lost a large amount of weight in one week. Potential reasons for this were recognised by staff assessing the patient and documented in the patient health record. The patient was weighed a few days later and it was established that the patient had not lost this amount of weight.

**Nutritional assessment**

50. A nutritional assessment should be completed within 24 hours of admission and should include information such as special dietary requirements, food allergies, likes or dislikes or any assistance the patient needs.

51. It is important to know a person’s nutritional preferences as they may lose the ability to communicate to staff what their preferences are. Where a person has a known cognitive impairment, this information may be obtained from the ‘Getting to Know Me’ document, family members or those who know the patient well.
52. We noted the person-centred audit tool used in some wards says that if a patient is able to state eating and drinking preferences then this information does not require to be completed. However, it is important to know a person’s nutritional preferences as they may lose the ability to communicate their preferences to staff.

53. Of the 13 patient health records reviewed, 12 patients had a nutritional assessment completed. We found the following.

- There was no place to record the patient’s likes and dislikes on the nutritional assessment. However, there was a prompt on the electronic system to record this information in the care plan; this was not seen to be done.
- Two patients were diabetic, however only one nutritional assessment reflected this.

**Oral healthcare assessment**

54. The Food, Fluid and Nutritional Care Standards state that the patient’s oral health status should be considered and recorded as part of the nutritional assessment for all patients.

55. There was no oral health assessment within the electronic patient health record system. However, two of the wards we inspected used paper versions of oral healthcare assessments. When this was completed, it was completed well and reviewed regularly.

**Falls assessment/screening**

56. There is a falls risk assessment bundle on NHS Lothian’s electronic patient health record system. This consists of five questions and should be completed for all patients on admission. If any of these questions are answered as ‘yes’, then a care plan should be completed.

57. All 13 patient health records had a falls assessment completed. However, we could not see how many were accurately completed within 24 hours of admission to hospital as we could only see assessment outcomes.

**Falls reassessment**

58. The falls reassessment should be completed weekly or following a patient fall or transfer to a different ward.

59. There were nine patients who required a falls reassessment. The majority of patients had this carried out, however, as reported previously, we could not be assured of their accuracy.

**Bedrail assessment**
60. Within NHS Lothian, a ‘rationale for the use of bedrails’ assessment has been incorporated into the falls bundle documentation and should be completed on admission for all patients. All of the patient health records reviewed had a fully completed bedrail assessment in place along with evidence of discussion with the patient for their use.

Mobility assessment

61. A mobility assessment was included in the electronic patient health record system. It detailed the level of assistance needed to mobilise and the patient’s ability to move in bed. All of the patient health records we reviewed had a mobility assessment in place that had been completed on admission to hospital.

62. During our inspection, we saw that bedside whiteboards were used to state how the patient mobilised. We were told that this information was often written up by the physiotherapists who would rely on nursing staff updating the electronic assessment. NHS Lothian should clarify whose responsibility it is to update the electronic assessments and care plans given that there is a multidisciplinary team approach and allied health professionals also have access to the electronic system. This will ensure that all staff adhere to their own professional standards of record keeping.

Preventing and managing pressure ulcers

63. NHS Lothian uses an adapted Waterlow risk assessment tool. Their own policy states that this assessment should be carried out within 6 hours of patient admission.

64. We reviewed 13 patient health records for pressure area care. Of these, 12 patients had an adapted Waterlow assessment completed. As previously reported, we were unable to establish how many assessments were accurately completed within 6 hours of admission due to the limitations of the electronic system. We found that one patient had a paper version of the adapted Waterlow assessment; this did not have the BMI section completed.

Waterlow reassessments

65. We found that it was not possible to see how each element of the previous Waterlow assessments had been calculated. This was because the electronic system only records the final score, meaning that the reasons for scores changing cannot be established. We found the following.

- There was not always a visible score next to the previous assessment dates. A senior charge nurse told us that this meant the score had not changed, however we saw identical scores in consecutive reassessments.
- One patient was incorrectly identified as having both healthy skin and broken skin on the same assessment.
One score had changed by a large amount, however due to the constraints previously identified, it was not clear which elements of the assessment had changed.

**Do not attempt cardiopulmonary resuscitation**

66. Do not attempt cardiopulmonary resuscitation (DNACPR) relates to the emergency treatment given when a patient’s heart stops or they stop breathing. Sometimes medical staff will make a decision that they will not attempt to resuscitate a patient. This is because they are as sure as they can be that resuscitation will not benefit the patient. For example, this could be when a patient has an underlying disease or condition and death is expected. When this decision is made, opportunities should be taken to have honest and open communication to ensure patients and their families are made aware of the patient’s condition. However, in some cases, clinical staff may decide not to share this information as they feel it may cause too much distress for the patient and their families. This decision should be clearly documented in the patient’s health records.

67. We reviewed three DNACPR forms during our inspection; two of these were fully and accurately completed with evidence of review.

68. The other DNACPR form did not have the review decision completed. However, there was evidence in the patient health record that the decision had been discussed with the appropriate person.

**Area for improvement**

2. NHS Lothian must ensure that all older people, who are admitted to hospital, are accurately assessed within the national standard recommended timescales. This includes nutritional screening and assessment, falls assessments and pressure ulcer risk assessments. There must be evidence of reassessment, where required. The NHS board should also ensure that the electronic patient health record system captures all the information required to demonstrate that the national standards are being met.

**Outcome 2: Person-centred care planning**

The patient (and their carer, if appropriate) is consulted and involved in decisions about their care.

Ensuring that all care is person-centred and that care plans are developed with the involvement of the patient and their carer, if appropriate.
69. Based on the outcome of assessments, some patients may be identified as unable to consent to treatment and their plan of care.

Decision-making, consent and capacity

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

Capacity assessments

71. An assessment of capacity to consent to treatment should be carried out where there are concerns regarding a person’s mental state (such as a cognitive impairment) or their ability to communicate due to a physical disorder. This will inform the decision of whether an AWI certificate is required.

72. We saw three patients whose cognitive assessment or physical condition should have prompted an assessment of capacity to consent to treatment. Two patients had this documented within their health record.

Adults with Incapacity certificates

73. One patient had four AWI certificates in their patient health record. We saw that one was out of date and had not been removed from the patient health record. Another certificate had been in place for a specific intervention. The other two certificates covered the same time period and both referred to an accompanying treatment plan. We asked medical staff to review these two certificates as it was not clear why there was duplication. There was one treatment plan in place for the patient which we noted did not include all interventions carried out such as artificial nutrition given. There was also no place to record the date that it was completed.

Care planning

74. Care plans are used to advise on care delivery and should show an evaluation of a patient’s care. These must have been agreed with the person receiving care or by those acting in the person’s best interests such as a power of attorney or guardian.

75. We saw that the majority of care plans in place were linked to assessments such as mobility, falls, pressure area care and MUST. However, we did not see any care plans in place for personal care. We also found the following.
• Staff could add care plans if required and we saw one in place for seizures.
• We did not see any evidence of patient involvement in any of the care plans.
• Some information was duplicated on a number of different care plans. We saw that care plans for falls and mobility contained similar information.

76. Some care plans were not always updated to reflect changes in the patient’s condition. We found the following.
• One patient’s care plan completed on admission to hospital stated ‘use of hoist for transfers’. However, the board above the patient’s bed stated ‘use of steady aid for transfers’. This showed that, although the information at the patient’s bedside board may be up to date, this information was not always transferred to the electronic care plan.
• Another patient was nil by mouth. However, the care plan stated that the patient was eating and drinking.
• Another patient was bed-bound but the care plan stated ‘mobile with assistance’.
• Another patient’s nutritional assessment stated they could independently make menu choices but their care plan stated they required assistance with this.

Care rounding
77. Care rounding 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.

78. All patients had care rounding documentation in place. The care round elements were generally well completed within the prescribed time frames with the majority of entries completed using the appropriate codes.

Areas for improvement
3. NHS Lothian must ensure that older people in hospital are involved in decisions about their care and treatment. Capacity for decision-making must be assessed in line with the Adults with Incapacity (Scotland) Act 2000. When legislation is used, it must be fully and appropriately implemented. This includes consulting with any appointed power of
attorney or guardian. The decision must be fully documented in the patient’s health record, including any discussions with the patient and their family.

4. NHS Lothian must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patients’ condition or needs. The care plans should also reflect that patients are involved in care and treatment decisions.

Outcome 6: Food, fluid and nutrition
The patient’s status is maintained or improved and appropriate food, fluid and nutrition is provided in a way that meets their individual needs.

Ensuring care for older people meets Healthcare Improvement Scotland’s Food, Fluid and Nutritional Care Standards.

Patient weighing equipment
79. All the wards we inspected had sitting scales which were in working order. Staff told us that alternative scales, such as hoist or bariatric scales, could be accessed from another ward within the hospital.

Dietetic and speech and language therapy cover and referrals
80. Staff told us that referrals to both the dietetic team and the speech and language therapy team were by telephone. Staff felt there was a good response time from both teams.

81. We saw three patients who required a dietetic and a speech and language therapy referral. All of these patients had evidence of input from both teams and a documented plan of care with ongoing review.

Identifying individual patient nutritional needs
82. We saw that nutritional boards were in place in the ward pantry areas. These include information on individual patient nutritional needs such as specialised diets. Individual patient nutritional needs were also identified during safety briefs, ward handovers and on a board above the patient’s bed.

83. We also saw that red water jugs and red napkins were in use in some of the wards we inspected. Staff told us that these were used for patients who needed assistance or encouragement at mealtimes.

Protected mealtimes
84. Protected mealtimes are used to reduce non-essential interruptions during mealtimes. This makes sure that eating and drinking are the focus for patients without unnecessary distractions.
We observed lunchtime in three of the wards we inspected. Overall we saw that mealtimes were inconsistently managed.

- Mealtime preparation was good in the majority of wards. However, in one ward we saw that patients’ tables were not cleared and they were not offered hand hygiene or positioned to eat their meals.
- In one ward, a bell was rung to signal to staff that the meal trolley had arrived in the ward.
- Although mealtime co-ordinators were able to describe their role’s responsibilities, we did not always see the role fulfilled in practice.
- Staff were generally engaged in mealtimes and managed to ensure that meals were served quickly. However, we noted in one ward that there was no input from registered nurses until all of the meals had been served. In one ward, a bell was rung to signal to staff that the meal trolley had arrived in the ward.

Assistance with eating and drinking

In the wards we inspected, we saw staff providing assistance to patients. For example, we saw staff opening packets and cutting up food. We also saw staff checking on patients. Staff told us that they could obtain adaptive aids, such as cutlery, from the occupational therapy department.

Provision of fluids and snacks

All patients had access to fresh drinking water, and a choice of hot and cold drinks were offered throughout the day.

A supply of snacks was available in all the wards we inspected. This included biscuits, yoghurts, and rice and custard pots. Staff told us that sandwiches were available and patients could order additional snacks on their menus.

Patient feedback on the food and snacks was mixed. One patient told us that it was not the kind of food they liked to eat. However, another patient told us that the meals were always good, always something they liked and was presented well.

Food record and fluid balance charts

Food and fluid balance charts are used to record how much patients are eating and drinking when there are concerns about their intake and output. These charts may be requested by medical staff, dietitians, and speech and language therapists or started by nursing staff.

None of the patient health records reviewed required a food record chart to be in place.
92. Five patients had fluid balance charts in place and none of the charts were fully and accurately completed. We found:

- fluid input and output were not always completed
- running totals for input and output were not always completed, and
- overall totals were not recorded to inform the next day’s care.

Artificial nutrition

93. Artificial nutrition is required for patients who are unable to eat or drink by the usual oral route and are unable to meet their nutritional requirements. Artificial nutritional support can be provided by using a feeding tube into the stomach or by a line into a vein.

94. We saw three patients receiving artificial nutrition via nasogastric tubes. There was a multidisciplinary team approach to all three patients’ care. We saw evidence of ongoing support from both the dietetic and the speech and language therapy teams.

95. All three patients had their artificial nutrition prescribed and there was evidence of tube management such as regular position checks. However, completion of documentation to record the administration of the artificial nutrition was variable. This meant that it was unclear how much of the artificial nutrition or water patients had received.

96. One patient’s artificial nutrition was recorded on the fluid balance charts. The chart did not record what fluids had actually been given. The other two patients’ artificial nutrition were recorded on two different recording charts. All of the charts were inconsistently completed. We found the following.

- The enteral feeding recording charts did not always document staff initials or what time the patient’s feed had finished.
- The other recording chart in use should be completed 4-hourly and document the volume remaining, volume infused and total volume infused. This was not always completed in the prescribed time frames and was only recorded daily on one chart.
- It was also unclear when water flushes were given as they were not always documented on either of the charts.

Areas for improvement

5. NHS Lothian must ensure that mealtimes are managed consistently in a way that ensures that patients are prepared for meals, including hand hygiene. The NHS board should also ensure that the principles of Making Meals Matter are implemented.
6. NHS Lothian must ensure that fluid balance charts are commenced and accurately completed for patients who require them and appropriate action is taken in relation to intake or output as required.

7. NHS Lothian must ensure that all prescribed artificial feeds are fully and accurately documented for all patients who are receiving them in line with national and local policy.

Outcome 7: Falls
Where avoidable, the patient does not fall during their stay in hospital.

Ensuring a systematic process is in place to assess older people for the risk of falling (which includes medication review) and individualised controls are implemented to prevent falls or reduce any risk to a minimum.

Falls risk management
97. Patients at risk of falls were highlighted during the ward safety briefs and handovers. We also saw that some wards highlighted the risk of falls on the board at the patient bedside with a falls symbol.

98. Ten patients were identified as being at risk of falls. All of these patients had a falls care plan in place. We saw good input from physiotherapists with some patients having documented goals.

Post falls management
99. We saw that patients who had fallen in hospital were discussed at the hospital-wide huddle so the learning could be shared. The senior charge nurses told us that falls are reported on the electronic reporting system. This is then reviewed to identify any trends or patterns so that improvements can be made to reduce the risk of falls.

100. We saw one patient who had fallen whilst in hospital. There was evidence of review by medical staff and it was reported on electronic reporting system.

Equipment
101. All wards had access to a supply of non-slip socks for patients who did not have appropriate footwear. We saw some patients wearing these.

102. Staff told us they could access high/low beds if required.

103. We saw a number of red Zimmer frames in use during our inspection. We have previously seen these in use in the Western General Hospital where they were being piloted for use by patients who forget to use walking aids. Staff in St John’s Hospital told us that they are used to identify which frames belong to
the ward rather than the patient. This demonstrates an inconsistent approach to their use within NHS Lothian, especially if a patient is transferred between hospitals.

Area of good practice

■ All wards had access to slipper socks for patients at risk of falls who required them.

Outcome 8: Pressure area care

Where avoidable, the patient does not acquire a pressure ulcer during their stay in hospital. If they are admitted with a pressure ulcer their care is tailored to their needs.

Ensuring care for older people is delivered in line with the Healthcare Improvement Scotland Standard for Prevention and Management of Pressure Ulcers, so patients can be identified as being at risk of a pressure ulcer and receive care to minimise the risk, including access to a local wound care formulary.

SSKIN bundles

104. The SSKIN bundle (skin, surface, keep moving, incontinence and nutrition) prompts staff to check patients’ skin more regularly and reduces variation in care practice. By checking the skin more regularly, staff can identify early signs of pressure damage sooner.

105. NHS Lothian uses a care rounding document which contains elements of the SSKIN bundle. The majority of patients had the SSKIN bundle well completed. Where these were not well completed, this was due to the location of red skin not being documented.

Specialist pressure relieving equipment

106. Staff told us that they had a supply of pressure relieving equipment within the wards such as pressure relieving cushions, boots and mattresses. Staff knew how to obtain additional equipment if needed from an external company.

Tissue viability service

107. Staff told us that they submit tissue viability service referrals electronically and can phone the service if required. They felt that they received timely responses.

Outcome 9: Care transitions

The patient is supported during periods of transition through a co-ordinated, person-centred and multi-agency planning approach and are able to return home (or to a homely setting or care service) as soon as they are well enough to do so.
Any additional support that they require at home is in place at the time of discharge.

Ensuring that:
- older people are discharged from hospital in a planned way and without delay
- partnerships between acute care settings and community care services support a co-ordinated approach to discharge, and
- medicines are reconciled as part of the discharge process.

**Discharge planning**

108. Effective discharge planning should begin at admission or shortly after admission to hospital.

109. We saw that there was a multidisciplinary team approach to discharge planning. The wards inspected had weekly ward rounds and multidisciplinary team meetings to discuss the patient’s progress and review their estimated date of discharge. Some of the wards also held a daily dynamic discharge meeting to identify if any patients could be discharged.

110. We saw evidence of discharge planning where appropriate. In one patient’s notes there was an early referral to restart care and discussions between medical staff and the patient and relatives about plans for discharge. We also observed the pharmacist chatting to this patient about discharge medication.

111. We saw that some patients had their estimated date of discharge recorded in the medical notes and we saw they had ongoing review of this.

**Patient flow and capacity**

112. With the exception of the medical admission unit, all wards had patients whose discharge was delayed. We are aware that there is a significant issue with delayed discharges throughout the hospital. We were told that this is mostly due to patients waiting for social care; this is outwith the control of staff on the wards. We were told that the delayed discharge team manage these delays through working closely with social care and other relevant agencies.

**Area of good practice**

- Proactive discharge planning.
Outcome 10: Skills and accountability

The patient is cared for by a safe number of staff who are knowledgeable, competent and accountable for the care they deliver.

A clinical and care governance framework is in place which will underpin the quality improvement agenda and safeguard high standards of care. Staff are aware of relevant legislation, national standards and key strategies which support this framework.

Staffing

113. We spoke with senior charge nurses who told us that a workforce planning assessment had been carried out in the last year for their ward areas. All wards had agreed staffing levels but these were short due to a number of vacancies. We were told that gaps were filled by using bank and agency staff and that a number of vacancies have now been filled. Staffing is discussed at the hospital-wide huddle to ensure safe staffing for the wards based on care needs rather than the number of patients.

Accountability

114. The senior charge nurses told us that they review all incidents reported on the electronic reporting system. This allows them to identify any patterns or trends which may require additional interventions or actions to make improvements.

115. All the wards we inspected had systems in place to capture feedback from patients. The senior charge nurses told us that there were no outstanding complaints at the time of our inspection. We saw many letters and cards from patients and relatives thanking staff for their care.

116. The senior charge nurses told us that they are supported by clinical nurse managers, the associate director of nursing and site management.

Training

117. The senior charge nurses told us that all nursing staff in the ward had a current personal development plan and appraisal. All staff complete mandatory training by attending face-to-face sessions and using an online resource. Some wards arranged ward-based education for a variety of topics if required. We were told that staff get some protected time for training due to the e-rostering system in use.

Link nurses

118. All wards had link nurses in place for food, fluid and nutrition, falls and tissue viability. The link nurses are registered nurses and clinical support workers. They are expected to attend training and meetings relevant to the topic and...
cascade this information back to staff within the ward. They are also expected to provide training and support within the ward. While there is no formal role descriptor, there is a clear expectation of the role. We were told in one ward that the role of the tissue viability link nurse has resulted in less referrals to the tissue viability service. Staff told us that they are now more competent at assessing and managing wounds.

Audits

119. We saw that various audits are being carried out at both ward and management level. Some wards told us that they have been involved in the care assurance standards work and continue to strive for improvements. Where needed, action plans were in place to address any issues identified through audit. We noted that some of the audits being used ask if an assessment has been done but do not ask if it is done correctly and within the time frame required by the national standards.

Area for improvement

8. NHS Lothian should have clear role descriptors for link nurses to ensure successful liaison between clinical areas of the hospital and specialist teams for the various aspects of healthcare.

Outcome 12: Communication

The patient is cared for by staff who communicate effectively in order to support safe, effective and person-centred care and individual patient communication needs are identified and met appropriately.

120. A range of information leaflets were available for patients and visitors in all wards. Topics included a variety of medical conditions, infection control topics, carer’s information and information about discharge support.

121. We observed the hospital-wide huddle. This was informative, efficient and gave a clear view of the position of the hospital. It was an opportunity to raise any safety concerns and for sharing any learning from incidents. All those present at the huddle were asked to confirm that their ward was safe to operate for the day.

122. During our inspection, we spoke with a number of staff, including charge nurses, nurses, healthcare support workers, allied health professionals and medical staff. All staff told us that they felt part of the ward team and that there was good team working. Staff felt able to raise any concerns with their colleagues, the senior charge nurse or the clinical nurse managers.
123. All wards used a safety brief and ward handover to communicate patient information to ward staff. Some wards also held a daily board round with medical and allied health professional staff. This was to update them on patient status and to highlight any patient concerns.

Documentation

124. As NHS Lothian is becoming ‘paperlite’, assessments, care plans and patient notes are recorded on the electronic system. However, as reported previously, agency staff still use paper versions.

125. Loose-leaf paper documents, such as NEWS charts, care rounding, fluid balance charts and drug prescription charts, were at the patients’ bedsides. DNACPR and AWI certificates were kept in a trolley within the ward area. The folders contained section dividers which made it easy to locate information.

126. We saw that the majority of documentation was timed, signed and dated with patient identifier number labels in place. We saw ward handover sheets in place for all patients who required them.
Appendix 1 – Areas of good practice

NHS Lothian

<table>
<thead>
<tr>
<th>Outcome 7: Falls</th>
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<tbody>
<tr>
<td>1️⃣ All wards had access to slipper socks for patients at risk of falls who required them (see page 23).</td>
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<table>
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<tr>
<th>Outcome 9: Care transitions</th>
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<tr>
<td>2️⃣ Proactive discharge planning (see page 25).</td>
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</table>
Appendix 2 – 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

| 1 | NHS Lothian should ensure that patient identifiable information, such as risk alerts and care needs details, are not on public display. This will ensure that patient privacy and dignity is respected (see page 10). |

Outcome 1: Screening and initial assessment

| 2 | NHS Lothian must ensure that all older people who are admitted to hospital, are accurately assessed within the national standard recommended timescales. This includes nutritional screening and assessment, falls assessments and pressure ulcer risk assessments. There must be evidence of reassessment, where required. The NHS board should also ensure that the electronic patient health record system captures all the information required to demonstrate that the national standards are being met (see page 16). This is to comply with the Care of Older People in Hospital Standards (2015) criteria 5.1, 11.1 and 11.2; the Food, Fluid and Nutritional Care Standards (2014) criteria 2.2, 2.3, 2.4 and 2.5; and the Standards for Prevention and Management of Pressure Ulcers (2016) criteria 3.2 and 3.3. |

Outcome 2: Person-centred care planning

| 3 | NHS Lothian must ensure that older people in hospital are involved in decisions about their care and treatment. Capacity for decision-making must be assessed in line with the Adults with Incapacity (Scotland) Act 2000. When legislation is used, it must be fully and appropriately implemented. This includes consulting with any appointed power of attorney or guardian. The decision must be fully documented in the patient’s health record, including any discussions with the patient and their family (see page 19). |
This is to comply with the Adults with Incapacity (AWI) (Scotland) Act 2000 part 5 – Medical Treatment and Research and Care of Older People in Hospital Standards (2015) criteria 3.4 and 3.5.

NHS Lothian must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patients’ condition or needs. The care plans should also reflect that patients are involved in care and treatment decisions (see page 19).

This is to comply with The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015), the Care of Older People in Hospital Standards (2015) criteria 1.1, 1.4, and 11.2a; and the Food, Fluid and Nutritional Care Standards (2014) criterion 2.9a.

**Outcome 6: Food, fluid and nutrition**

5 NHS Lothian must ensure that mealtimes are managed consistently in a way that ensures patients are prepared for meals, including hand hygiene. The NHS board should also ensure that the principles of *Making Meals Matter* are implemented (see page 22).

This is to comply with the Food, Fluid and Nutritional Care Standards (2014) criteria 4.7 and 4.8.

6 NHS Lothian must ensure that fluid balance charts are commenced and accurately completed for patients who require them, and appropriate action is taken in relation to intake or output as required (see page 22).

This is to comply with the Food, Fluid and Nutritional Care Standards (2014) criterion 4.1g.

7 NHS Lothian must ensure that all prescribed artificial feeds are fully and accurately documented for all patients who are receiving them in line with national and local policy (see page 22).

This is to comply with the Complex Nutritional Care Standards (2015) criterion 3.3.

**Outcome 10: Skills and accountability**

8 NHS Lothian should have clear role descriptors for link nurses to ensure successful liaison between clinical areas of the hospital and specialist teams for the various aspects of healthcare (see page 26).
Appendix 3 – List of national guidance

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

- **Best Practice Statement for Working with Dependent Older People to Achieve Good Oral Health** (NHS Quality Improvement Scotland, May 2005)
- **Care of Older People in Hospital Standards** (Healthcare Improvement Scotland, June 2015)
- **Best Practice Statement for Prevention and Management of Pressure Ulcers** (NHS Quality Improvement Scotland, March 2009)
- **Standards for Prevention and Management of Pressure Ulcers** (Healthcare Improvement Scotland, September 2016)
- **Food, Fluid and Nutritional Care Standards** (Healthcare Improvement Scotland, October 2014)
- **Complex Nutritional Care Standards** (Healthcare Improvement Scotland, December 2015)
- **Adults with Incapacity (Scotland) Act 2000 Part 5 – Medical treatment and research**
- **Standards of Care for Dementia in Scotland** (Scottish Government, June 2011)
- **Scottish Government Health Directorate, Chief Medical Officer (CMO)(2013)18: Safer Use of Medicines - Medicines Reconciliation: Revised Definition, Goals and Measures and Recommended Practice Statements for the Scottish Patient Safety Programme** (Scottish Government, September 2013)
- **The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives** (Nursing & Midwifery Council, January 2015)
- **Generic Medical Record Keeping Standards** (Royal College of Physicians, November 2009)
- **Allied Health Professions (AHP) Standards** (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, January 2016)
Appendix 4 – Inspection process flow chart

Before inspection
- Healthcare Improvement Scotland issues self-evaluation framework to NHS boards
- NHS board undertakes self-evaluation exercise and submits outcomes to Healthcare Improvement Scotland
- Healthcare Improvement Scotland reviews self-evaluation submission to inform and prepare on-site inspections
- Healthcare Improvement Scotland visits NHS board

During inspection
- Inspection team arrives at hospital
- Inspections of selected wards and departments
- Individual discussions with senior staff or operational staff, or both, and patients
- Feedback session with NHS board and senior hospital staff
- Follow-up inspection of hospital if areas of significant concern identified

After inspection
- Inspection report and NHS board improvement action plan published
- 16 weeks after inspection, NHS board submits updated improvement action plan to Healthcare Improvement Scotland