Unannounced Inspection Report – care for older people in acute hospitals

St John’s Hospital | NHS Lothian

3–5 September 2013
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1 About this report

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

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

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

This report sets out the findings from our unannounced inspection to St John’s Hospital, NHS Lothian from Tuesday 3 September to Thursday 5 September 2013.

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

The inspection team was made up of four inspectors and two public partners, with support from a project officer. The team also included a clinical advisor from another NHS board who provided clinical advice and support to the team. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. A key part of the role of the public partners is to talk to patients and listen to what is important to them. Membership of the inspection team visiting St John’s Hospital can be found in Appendix 2.

The report highlights areas of strength, areas for improvement and areas for continuing improvement. All areas for improvement from this inspection can be found in Appendix 1 on page 18. Wherever possible, the areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action. A list of relevant national standards, guidance and best practice can be found in Appendix 3.

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

St John’s Hospital, Livingston, serves the Lothian region. It has 532 staffed beds and a full range of healthcare specialties, including a 24-hour accident and emergency department and specialist services such as burns treatment and plastic surgery. The hospital has a short stay elective (planned) surgical centre which treats around 3,000 day surgery patients a year from across Lothian. The hospital is also developing a regional centre for elective surgery, including a centre for minimally invasive surgery.

We carried out an unannounced inspection to St John’s Hospital, NHS Lothian from Tuesday 3 September to Thursday 5 September 2013.

We inspected the following areas:

- medical admissions unit
- stroke unit
- ward 8 (medicine of the elderly)
- ward 14 (orthopaedics)
- ward 18 (plastic surgery)
- ward 19a (ear, nose and throat)
- ward 21 (general medicine), and
- ward 25 (general medicine).

We also visited the accident and emergency department, discharge lounge, primary assessment area and ward 20 (burns unit).

Before the inspection, we reviewed NHS Lothian’s self-assessment 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 care of people with dementia and cognitive impairment, and nutritional care and hydration. Ensuring that older people are treated with compassion, dignity and respect is a focus on all our inspections.

On the inspection, we spoke with staff and used additional tools to gather more information. In seven wards, we used a formal observation tool. We carried out 16 periods of observation during the inspection. In each instance, members of our team observed interactions between patients and staff in a set area of the ward for 20 minutes.

We also carried out patient interviews and used patient questionnaires. We spoke with 29 patients during the inspection. We received completed questionnaires from 75 patients.

As part of the inspection, we reviewed 47 patient health records to check the care planned and delivered was as described in the care plans. For this inspection, we reviewed 45 of the 47 patient health records for dementia and cognitive impairment. Out of these 47 patient health records, we also reviewed 45 of them for nutritional care and hydration.
Areas of strength
We noted areas where NHS Lothian was performing well in relation to the care provided to older people in acute hospitals.

We saw warm, caring and meaningful interactions between staff and patients. Care was carried out in a way that maintained patient dignity and was compassionate and respectful. This included many good examples of patients being helped or encouraged to eat and drink.

The Rapid Occupational Therapy Assessment Service (ROTAS) aims to prevent patients over the age of 65 years from being unnecessarily admitted to hospital or helps patients achieve a safe and effective discharge from hospital. During and after their stay in hospital, the team work closely with the patient, their relatives and other agencies across acute and community services.

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

Do not attempt cardiopulmonary resuscitation (DNACPR) documentation and national policy was not always followed.

Screening for cognitive impairment was not routinely carried out in patients over 65 years when they were admitted to hospital.

The role of the dementia champions in this hospital was unclear and it was not evident how they are improving dementia care throughout the hospital.

The ward environments we inspected need to be made more suitable for people with dementia and cognitive impairment.

Although we found that care delivered to patients appeared to be appropriate and of a good standard, we found that the documentation available for staff to use to document and evidence the care delivered does not allow them to demonstrate assessment, planning and evaluation of care. This makes it difficult to follow how patients’ care is being managed.

Some of the issues identified in this report also lead us to believe that ward staff require more support from senior management. This will ensure that staff at St John’s Hospital have access to the same single system resources and service improvements as the rest of NHS Lothian. This will then help staff to improve the patient’s experience while they are in St John’s Hospital.

What action we expect NHS boards to take after our inspection
This inspection resulted in two areas of strength and 15 areas for improvement. A full list of the areas for improvement can be found in Appendix 1 on page 18.

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

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

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

Treating older people with compassion, dignity and respect

All wards inspected were mixed sex wards. Patients were accommodated in either single sex bays or single rooms. Designated male and female toilets and shower facilities were available.

Patients appeared to be well groomed, dressed appropriately, comfortable and well cared for. The majority of patients were dressed in their own clothes.

Most of the wards inspected were bright and fresh smelling. However, we found that some wards, in particular the medical admissions unit, were poorly lit in some areas. We also found that the corridors in many of the wards inspected were cluttered. This could restrict patients who like to walk in the ward and could increase the risk of patients falling.

Information displayed above the beds about personal care needs was kept to a minimum to maintain patients' privacy. Personal items, such as patients' spectacles, hearing aids and water jugs were easily accessible for patients in all wards inspected. However, on one ward inspected, we saw that patients' walking aids were not always easily accessible for patients to use. They were left at the end of the bed rather than next to patients while they sat in chairs at their bedside.

All the wards inspected had a nurse call system in use. We saw that call handsets were placed near to patients to make them accessible. With the exception of one ward, we saw that staff dealt with patients' requests for help promptly. On this ward, we heard buzzers ringing for lengthy periods of time before being answered.

Although wards were busy during our inspection, we found that most were managed in a calm and organised manner and staff worked well together. This contributed to patients' care being carried out in a way that maintained patient dignity and that was compassionate and respectful. However, we believe that leadership and teamworking was working less well on one ward. We found little evidence of a joined-up approach to caring for patients between the trained (nursing) staff and the untrained staff (clinical support workers). These two staff groups appeared to be working in isolation which was resulting in a lack of supervised, co-ordinated care for the patients on this ward.

Patient comments

Through our surveys and interviews, patients had the opportunity to give us their opinion of the care they received. Overall, patients were positive about the care and help they received. Of the 75 patients who completed our questionnaire, 85% stated that they had been given clear information about their condition and treatment, and 95% said the quality of care they received was good.

- ‘... a very caring and compassionate place. On a day when I have felt sad or worried they were always there to comfort and care. I cannot praise my stay in [ward] enough. Their humour, nursing skills... has been second to none.’
- ‘This is one of the best hospitals I have ever been in for care and attention. The staff are very helpful and cheery.’
- ‘Staff are very good and considerate and very helpful.’
- ‘During my stay, they have cared for me and supported me emotionally, with great care.’
- ‘The staff in this hospital are the best I know.’
Some patients told us of some concerns and worries 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.’

- ‘The only complaint I have is if I need the toilet I seem to have to wait a while for help with commode etc.’

- ‘A lot of the time staff spend on ‘red tape’ issues which prevent them from carrying out their prime task - nursing.’

**Patient and staff interactions**

We saw and heard good interactions between a range of staff and patients, and saw that patients were treated with compassion, dignity and respect. Staff were friendly and polite and talked to patients in a quiet, gentle and respectful manner, addressing patients by their preferred name. On many occasions, we heard staff introduce themselves to patients and check that they were happy to have care and treatment carried out at that time.

For example, on one ward, we saw a patient who was very agitated and was repeatedly calling out for help. We saw that staff were very patient with him, responding promptly when he called out and spending a lot of time with him offering reassurance.

However, on many of the wards inspected, patients told us they were not aware of who was in charge of the ward.

**Care and comfort rounding**

We saw that care and comfort rounding was in place in most of the wards inspected. This is when staff check on individual patients at defined regular intervals to anticipate any care needs they may have, for example pain relief or needing the toilet.

The care and comfort rounding sheet is intended to record the care delivered during the ‘care round’. However, we found that this documentation was not consistently completed in the wards inspected. As a result, we could not be assured of the care being delivered to patients, despite staff telling us what care they had provided.

**Support for patients and carers**

We were told that the hospital has volunteers across a number of wards to support staff and patients, such as helping at mealtimes and keeping patients company.

We briefly visited the discharge lounge. This is used by patients who have been discharged from their ward and are waiting for transport home. The lounge is open Monday–Friday. The discharge lounge was difficult to find. We were told that the lounge had moved location in the hospital a couple of times. The environment is bland with limited suitable furniture, for example patients were having to sit on hard chairs. We were told that patients sometimes had to wait for several hours in the lounge for their discharge medication. Staff made efforts to make sure that patients did not sit for long periods and that they were provided with meals.

On one ward (ward 25), there was a small room for relatives and carers to use with tea-making facilities available. Staff had also identified that the main public toilets were some distance from the ward, so had requested visitor toilets on the ward when the ward was recently refurbished.
Opportunities for patient activities and social interactions

Opportunities and activities to encourage patients to socialise while they are in hospital can help to keep them active and maintain their current level of physical and mental functioning.

Some wards had day rooms, but these were not well used by patients. We were told that a successful music session trial had been held on some wards and that pet therapy dogs are being introduced.

We saw a volunteer carrying out nail and hand care for patients on the stroke unit. We also noted that a hairdresser had a small room on this unit, which was available for patients from other areas of the hospital to use.

However, patients told us that there were limited activities to keep them occupied during the day, especially for those patients who are in hospital for a long time such as patients waiting for a home care package. Staff confirmed that they are not able to provide ongoing stimulation and purposeful activities for those patients who are ready to be discharged home, but have to stay in hospital.

Do not attempt cardiopulmonary resuscitation documentation

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 make sure 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.

From the DNACPR forms we looked at, we found examples where the DNACPR documentation and national policy were not followed.

- We saw three DNACPR forms with no review dates. With these same three patients, we saw that their health records showed that discussions about DNACPR had taken place with the patients and their families. However, this had not been documented on any of the DNACPR forms.
- We saw another two DNACPR forms where there was a note in the patients’ health records that there should be a discussion with the patients and their families. Although there was not a significant time lapse, neither of these discussions had taken place by the time of our inspection.
- We saw one DNACPR form where there was no discussion with the patient and their family noted on the DNACPR form or in the patient’s health record. There was no reason documented why this discussion was possibly not appropriate.
- We saw one DNACPR form which had no reason stated for the form being in place. The section in the form where medical staff should detail why CPR would be unlikely to be successful had been left blank.

Rapid Occupational Therapy Assessment Service (ROTAS)

St John’s Hospital has a Rapid Occupational Therapy Assessment Service (ROTAS). The main aim of this service is to prevent unnecessary admission to hospital for patients coming into the accident and emergency department. Or, for those patients who are admitted to
hospital, to help those patients achieve a safe and effective discharge within 72 hours of admission and, where possible, prevent unnecessary readmission to hospital.

Medical staff can refer those patients over the age of 65 years to ROTAS who meet specific criteria, such as having a history of falls. The ROTAS team carry out a comprehensive occupational therapy assessment.

We were told that, since January 2013, there had been 365 referrals to the ROTAS team, with approximately one-third of these patients discharged without admission to hospital. Further services are then available to refer patients to prevent readmission, such as arranging crisis care, social work, community occupational therapists, carer support, the Red Cross volunteers and community pharmacists. The ROTAS team will also contact the patient and their relatives the day after they leave hospital to identify any concerns. Patients are also provided with contact details to allow them to contact the team for further advice and support up to 3 months following discharge from the service.

If a patient is admitted to hospital, the ROTAS assessment will be shared with the ward team. The ROTAS team and ward-based occupational therapists work closely together to provide a 7-day service for patients.

This is a good example of healthcare staff across both acute and community services working well together and recognising the contribution and needs of the patient and their relatives and carers.

Discharge planning
We saw no evidence of effective discharge planning in the patient health records reviewed. Effective discharge planning should start after a patient is admitted to hospital and continue throughout the patient's stay in hospital. Although NHS Lothian has a discharge planning sheet contained within the patient health record, we saw that these were not being completed.

Patient movement
People with dementia or a cognitive impairment should not be moved or 'boarded' unless this is part of their medical treatment or part of their care pathway. Moving patients can increase their level of confusion and lengthen their stay in hospital. 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. For example, medical patients being boarded outwith the appropriate specialty to surgical wards.

Staff told us that, on occasions when patients were moved to meet the capacity needs of the hospital, it could be difficult to get the appropriate specialty doctor to review the patient or complete the patient’s discharge documentation. During our inspection, we saw some examples of patients who had been moved to another ward outwith their specialty.

Area of strength
- The Rapid Occupational Therapy Assessment Service (ROTAS) aims to prevent patients over the age of 65 years from being unnecessarily admitted to hospital or helps patients achieve a safe and effective discharge from hospital. During and after their stay in hospital, the team work closely with the patient, their relatives and other agencies across acute and community services.
Areas for improvement

1. NHS Lothian must ensure that the implementation of care rounding is supported by adequate individualised care planning and evaluation of a patient's care.

2. NHS Lothian must ensure that patients have access to a range of activities and stimuli to help keep them active and maintain their current level of physical and mental functioning.

3. NHS Lothian must ensure that clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR).

4. NHS Lothian must ensure that effective discharge planning begins on or shortly after a patient is admitted to hospital.

Dementia and cognitive impairment

Screening and assessment of people with dementia and cognitive impairment

Across the wards inspected, we found that cognitive screening was poor. From the patient health records we reviewed, we found that just over 27% had been screened for cognitive impairment using an abbreviated cognitive screening tool (AMT 4 or AMT 10). The patient admission documentation does not provide a prompt for staff to carry out cognitive screening.

We found that there was a lack of understanding by staff of the need for cognitive screening and how results from this screening then informed a plan of care for the patients, such as informing or triggering further actions to be taken.

We saw an example where a patient had cognitive screening carried out on admission to hospital. Although they scored highly in terms of no cognitive impairment, it was documented that the patient did not recall a recent admission to hospital. A separate cognitive assessment was carried out on the same day. This assessment was not scored or totalled, so provided no result. There was no associated care plan for this patient.

We also found that staff's awareness and knowledge of delirium was poor and we saw little evidence of screening for delirium.

We found that this inconsistent approach to cognitive screening also applied to patients transferred from other NHS Lothian acute hospitals to St John’s Hospital. We also found that patients coming into hospital for an elective (planned) admission were not being screened.

Record-keeping and care planning for people with dementia and cognitive impairment

We found that the patient health records we reviewed were difficult to follow and were not always legible. Staff were not always fully documenting patients’ personal details and we also found a lack of documentation to demonstrate that care planning was person-centred. The documentation available for staff to use does not allow them to evidence individualised care needs or demonstrate patient choice or preferences. Care plans were 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.
For example, we saw a patient who was being well supported by staff. This patient was very agitated and staff were able to tell us what action and techniques they used to lessen the patient’s anxiety. However, none of this information was documented in the patient’s health record. This means that staff unfamiliar with this patient would be unaware of how to support them, for example if the patient was transferred to another ward.

There appears to be an inconsistent approach to care planning, particularly for patients with a cognitive impairment. For example, we reviewed the health record of a patient with a known diagnosis of cancer, but who was in hospital for an unrelated matter. The patient had been seen by the palliative care team shortly after admission to hospital. There was evidence of contact with the patient’s family. Staff had made arrangements for follow-up support in the community once the person was discharged from hospital. In comparison, a patient on the same ward had a known diagnosis of dementia and was in hospital for an unrelated matter. There was no referral for any follow-up support from the hospital’s psychiatric service. There was limited contact with the patient’s family. There was no evidence of any arrangements made to make sure follow-up support was available in the community once the patient was discharged from hospital.

NHS Lothian uses the ‘This is Me’ document to request and record key personal information about patients. This allows staff to get to know the patient and their carers and provide personalised care and treatment to the patient. Patients and their carers can highlight personal information such as habits, background, likes and dislikes and things that are important to them. It also allows carers to identify how involved they wish to be during the patient’s time in hospital.

We found limited use of this document in the wards inspected and it was unclear how it was being used to inform care for patients.

- One patient was noted as being ‘disorientated’ on their admission documentation, but had nothing documented on how to manage this and nothing was written in their ‘This is me’ document.
- One patient with a known history of Alzheimer’s had ‘happily confused’ written in their patient health record. This is not respectful language to use when describing a patient with dementia. There was no plan of care for their dementia. However, we noted that there was a plan of care for the patient’s cardiovascular disease. The patient’s ‘This is me’ document had been completed, but was not signed or dated. This makes it unclear who had provided the information or how soon this took place after the patient’s admission to hospital. We found a one-page sheet within the patient health record which was to be used to help orientate the patient and reduce any anxiety they may feel. This explained that they were in hospital, the reason they were in hospital and to speak to a nurse if they needed anything. However, as this was in their health record and not at the patient’s bedside, this was of no benefit to the patient.

**Adults with Incapacity (Scotland) Act 2000**

From the patient health records we reviewed, we found that there was a poor understanding by both medical and nursing staff of the interpretation and application of the Adults with Incapacity Act. This is used to authorise treatment for patients who are unable to consent themselves. In the patient health records reviewed, we found there was a lack of documented assessment of capacity for patients with a known or suspected cognitive impairment. Where adults with incapacity forms were in place, these were poorly completed.

For example, we noted a patient who had ‘new confusion’ noted on their admission to hospital. Cognitive screening had not been carried out and there was no plan of care for this patient. There was a completed adult with incapacity form in place to cover a specific time...
period (one month) and specific medical treatment and care. However, before the patient’s surgery took place, the patient had signed a surgical consent form for their operation. Both documents had been completed on the day the patient was admitted to hospital. While this may be appropriate, it was unclear from the patient health record which form of consent was used to perform the patient’s surgery.

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. From the patient health records we reviewed, we found little information about patients with an appointed power of attorney and what decisions this person could make on behalf of the patient.

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

People with dementia or a cognitive impairment can benefit from environments that are adapted to limit potential confusion and distress. Across the wards inspected, we saw little had been done to improve the environment for people with dementia or a cognitive impairment. We saw that some wards had toilet and bathroom signage in place.

There was limited use of pictures, colours or shapes to help patients differentiate between individual bedrooms or ward bays. There was also no use of contrasting colours to identify different areas in the wards, such as toilets.

On many of the wards inspected, clocks were small, with no date or day information to help orientate patients. They were also positioned too high up on the walls making them difficult for patients to see.

We found that general ‘way finding’ signage directing patients and visitors to wards and departments could be improved. Signage was small and not well contrasted. It is particularly difficult to find your way from the front entrance to many of the wards, especially when using the lifts as there is no signage in the lifts to identify where wards are located. We were told that, during visiting hours, volunteer ‘guiders’ are available to help patients and visitors to find their way round the hospital.

We noted that ward 25 had been recently refurbished. However, the flooring on the ward may not be helpful to people with dementia or a cognitive impairment. There were many different coloured areas and shapes, such as circles on the floor. This could create a barrier for patients, such as thinking blue circles were puddles of water. This can impact on the ability of people with a cognitive impairment to move around the ward.

**Dementia champions**

We found that some wards had dementia champions. However, we found it was unclear how this role was developing and how they are improving dementia care throughout the hospital.

**Psychiatric liaison services for older people**

There is no dedicated psychiatric liaison service for older people in St John’s Hospital. Staff told us they can access advice and support from the older people’s mental health team and from other staff who work on the mental health wards in the hospital. We were told that funding has recently been put in place for a consultant liaison psychiatrist.
Areas for improvement

5. NHS Lothian must ensure that all older people who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment. This includes people admitted to hospital for an elective (planned) procedure.

6. NHS Lothian must ensure that patients identified as having a cognitive impairment have a personal care plan in place. This care plan should identify the specific needs of the patient and how staff will meet these needs.

7. NHS Lothian must ensure that staff record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing documentation. This information should be used and be shared with all staff in direct contact with the patient.

8. NHS Lothian must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. When legislation is used, this must be fully documented in the patient health record, including any discussion with the patient or family.

9. NHS Lothian should ensure that systems are in place to identify and record when patients have appointed a welfare power of attorney.

10. NHS Lothian must ensure that improvements to the ward and hospital environment are carried out to make it more suitable for people with dementia and cognitive impairment.

Nutritional care and hydration

Nutritional assessment and personalised care plans

NHS Lothian’s self-assessment states that, as part of the hospital admission process, patients have nutritional screening carried out using a validated tool (Malnutrition Universal Screening Tool [MUST]). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. This includes information on a patient’s height and weight, body mass index (BMI), any unplanned weight loss and whether the patient is acutely ill or has not eaten for more than 5 days. The tool also states that reassessment will take place regularly while the patient remains in hospital.

Of the 45 patient health records reviewed for nutritional care and hydration, 36 (80%) had nutritional screening carried out within 24 hours of admission. As we found that 20% of patients had not been screened, there needs to be a more consistent approach to carrying out nutritional screening.

We also noted that there were at least three different nutritional screening forms in use across the hospital. The lead dietitian seemed unaware of this lack of standardised approach when we drew this to their attention.

We could not determine whether patients’ weight recorded on the nutritional screening tool was estimated or was an actual measured weight. For example, a patient may be weighed using scales, staff may estimate a weight or the patient may tell staff themselves. The method of how patients were weighed is not recorded in the nutritional screening tool. This can have an impact on the accuracy of screening and subsequent treatment planned. We also noted an example where a patient had nutritional screening carried out within 24 hours...
of admission and then again the following day. The patient’s height varied by 4 inches between these two assessments. This had an impact on the patient’s nutritional risk score following screening.

Another patient was noted to have lost a significant amount of weight in a short period of time (16 kg in one month). Although staff told us that this was due to medical reasons, there was no documentation to support this. We saw that this patient had received regular nutritional screening which showed continuing weight loss. However, the patient’s screening results were inaccurate and the patient was not referred to the dietitian until nearly 4 weeks after admission.

We noted that the nutritional screening forms include a section for staff to ask patients some generic questions for food, fluid and nutrition. This means that staff are not carrying out a personalised, person-centred assessment of an individual patient’s needs.

We found that there was no evidence of further nutritional assessments where these were needed and no nutritional care plans in place. There was very little documented information about patients’ dietary likes or dislikes.

For example, one patient was registered blind. There was no information in the patient health record about this patient’s nutritional and hydration needs or how this patient may need help or support to eat and drink.

**Food and fluid balance charts**

Food and fluid balance charts are used to record how much patients are eating and drinking when this is necessary. We found that there was little information in the patient health records of the reason why patients were on food and/or fluid balance charts.

We also found that these charts were not always completed. This has a subsequent impact on medical and nursing treatment plans if a patient’s intake is not being accurately recorded or calculated. Additionally, we found gaps in the care and comfort rounding sheets used to show that fluids had been offered to the patient.

We saw a patient with fluid thickener at their bedside. This can be used for patients who have difficulty swallowing fluids. There was no information documented in the patient health record about how this should be used, at what stage and for what fluids. The patient had a fluid balance chart to record how much they were drinking. This was poorly completed. The patient health record also stated that this patient needed help when eating and drinking. There was no plan of care in place to provide information on what support was needed or what support was being provided.

**Provision and assistance of nutrition and hydration**

We observed three mealtimes across all wards during our inspection: breakfast, lunch and dinner. In the majority of wards inspected, we found that mealtimes were well managed and protected mealtimes had been implemented. This reduces non-essential interruptions during mealtimes to make sure that eating and drinking are the focus for patients without unnecessary distractions.

Some wards had allocated staff to specific bay areas which meant that meals were served to patients efficiently and quickly using smaller trolleys loaded from the main food trolley. Staff remained in or near to their allocated area to support and encourage patients during their meals. However, staff on one ward told us that they did not implement protected mealtimes as it was too difficult to do due to interruptions. Staff on all wards told us that there was not a guaranteed ‘fixed’ time of when the meal trolley would arrive on their ward. There appeared
to be a large ‘window’ of time when they were to expect the meal trolley on their ward. This makes it difficult for staff to prepare patients for meals when they may then have to wait for some time before their meal arrives.

Despite this, we saw that when the food arrived on the wards, this was served to patients in a timely manner. All patients who needed help with eating and drinking were given this in a caring and compassionate way. On some wards, we were told that patients who needed help with eating and drinking were identified during the daily ward safety brief.

Staff told us that they used a coloured tray system to identify those patients with specific eating and drinking needs. We only saw staff using this system in one ward inspected.

In all the wards we inspected, we saw limited opportunities given to patients to wash their hands or use hand wipes before their meal. On one ward, we also noted that the vast majority of patients were issued with a green apron before receiving their meal. We did not see individual patients being asked if they wanted to use an apron.

We noted that supplement drinks were prescribed for administration at ward drug round times. This meant that they were given at the same time as a patient’s meal. Supplement drinks should be given outwith mealtimes.

Using adapted cutlery and equipment, such as plate guards, can help patients maintain independence, preserve dignity and increase confidence. Although we saw instances where the use of adaptive aids had been identified in some patient health records, these were not being used.

**Menus and provision of snacks**

We noted good menu choices available for patients. The majority of patients we spoke with were complimentary of the quality of the food and the choices on offer.

Snacks are available outwith mealtimes. All wards had a choice of hot and cold drinks available.

**Dietetic, speech and language therapists and catering services**

There was evidence of good communication between ward staff and the dietitians, speech and language therapists, and catering services. We saw evidence of referrals to the dietitians and speech and language therapists, as well as evidence of their input.

We were told that staff can order high protein meals, such as bacon and eggs for any patients they feel are at risk of weight loss without having to speak to the ward dietitian. This allows ward staff greater flexibility in being able to offer patients a wider choice of foods.

We were told that ward staff will inform the kitchen when a patient is transferred between wards or to the discharge lounge to make sure their meal is sent to them. Staff also inform the kitchen of any new admissions to their ward to make sure these patients receive a meal at the same time as the rest of the patients on the ward.

Staff told us that the catering staff are flexible in terms of meeting individual patient dietary requirements. This is facilitated by the fact that all food is cooked on site, including freshly made rolls and cakes.
Area of strength

- There was evidence of good communication between ward staff and the dietitians, speech and language therapists, and catering services.

Areas for improvement

11. NHS Lothian must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital.

12. NHS Lothian should ensure the correct nutritional screening documentation is in place throughout the hospital in line with NHS Lothian policy.

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

14. NHS Lothian must ensure that patients’ intake of food and fluid is accurately recorded, monitored and that necessary action is taken if a patient’s intake is inadequate.

15. NHS Lothian must ensure that protected mealtimes are implemented on all wards and make sure that all non-essential activity (clinical and non-clinical) is stopped during patient mealtimes.
**Appendix 1 – Areas for improvement**

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

### Treating older people with compassion, dignity and respect

<table>
<thead>
<tr>
<th>NHS Lothian:</th>
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</table>
| 1 | must ensure that the implementation of care rounding is supported by adequate individualised care planning and evaluation of a patient’s care (see page 11).  
This is to comply with Nursing & Midwifery Council, Record Keeping: Guidance for nurses and midwives (2009). |
| 2 | must ensure that patients have access to a range of activities and stimuli to help keep them active and maintain their current level of physical and mental functioning (see page 11).  
This is to comply with Standards of Care for Dementia in Scotland, page 25. |
| 3 | must ensure that clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR) (see page 11).  
This is to comply with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy – Decision Making and Communication (Scottish Government, May 2010). |
| 4 | must ensure that effective discharge planning begins on or shortly after a patient is admitted to hospital (see page 11).  
This is to comply with Clinical Standards for Older People in Acute Care, Standard 5c. |

### Dementia and cognitive impairment

<table>
<thead>
<tr>
<th>NHS Lothian:</th>
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</table>
| 5 | must ensure that all older people who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment. This includes people admitted to hospital for an elective (planned) procedure (see page 14).  
This is to comply with Clinical Standards for Older People in Acute Care, Standard 2. |
### Dementia and cognitive impairment (continued)

<table>
<thead>
<tr>
<th>NHS Lothian:</th>
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<tr>
<td><strong>6</strong> must ensure that patients identified as having a cognitive impairment have a personal care plan in place. This care plan should identify the specific needs of the patient and how staff will meet these needs (see page 14).</td>
</tr>
<tr>
<td>This is to comply with Standards of Care for Dementia in Scotland, page 15.</td>
</tr>
<tr>
<td><strong>7</strong> must ensure that staff record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing documentation. This information should be used and be shared with all staff in direct contact with the patient (see page 14).</td>
</tr>
<tr>
<td>This is to comply with Standards of Care for Dementia in Scotland, page 26.</td>
</tr>
<tr>
<td><strong>8</strong> must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. When legislation is used, this must be fully documented in the patient health record, including any discussion with the patient or family (see page 14).</td>
</tr>
<tr>
<td>This is to comply with Adults with Incapacity (Scotland) Act 2000 Part 5 - Medical treatment and research.</td>
</tr>
<tr>
<td><strong>9</strong> should ensure that systems are in place to identify and record when patients have appointed a welfare power of attorney (see page 14).</td>
</tr>
<tr>
<td><strong>10</strong> must ensure that improvements to the ward and hospital environment are carried out to make it more suitable for people with dementia and cognitive impairment (see page 14).</td>
</tr>
<tr>
<td>This is to comply with Standards of Care for Dementia in Scotland, page 26.</td>
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### Nutritional care and hydration

<table>
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<th>NHS Lothian:</th>
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<tr>
<td><strong>11</strong> must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital (see page 17).</td>
</tr>
<tr>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.1.</td>
</tr>
<tr>
<td><strong>12</strong> should ensure that the correct nutritional screening documentation is in place throughout the hospital in line with NHS Lothian policy (see page 17).</td>
</tr>
</tbody>
</table>
### Nutritional care and hydration (continued)

**NHS Lothian:**

<table>
<thead>
<tr>
<th>13</th>
<th>must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients (see page 17).</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.7.</td>
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<tr>
<th>14</th>
<th>must ensure that patients’ intake of food and fluid is accurately recorded, monitored and that necessary action is taken if a patient’s intake is inadequate (see page 17).</th>
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<tr>
<td></td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.6.</td>
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<tr>
<th>15</th>
<th>must ensure that protected mealtimes are implemented on all wards and make sure that all non-essential activity (clinical and non-clinical) is stopped during patient mealtimes (see page 17).</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.7.</td>
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Areas for continuing improvement are improvements that the NHS board has already identified and started to address. We acknowledge the work carried out by the NHS board at the time of inspection and encourage progress in these areas.

### Areas for continuing improvement

| None |

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Healthcare Improvement Scotland Unannounced Inspection Report (St John’s Hospital, NHS Lothian): 3–5 September 2013
Appendix 2 – Details of inspection

The inspection to St John's Hospital, NHS Lothian was conducted from Tuesday 3 September to Thursday 5 September 2013.

The inspection team consisted of the following members:

**Ian Smith**
Senior Inspector

**Claire Blackwood**
Inspector

**Gareth Marr**
Inspector

**Irene Robertson**
Inspector

**Karen Goudie**
Clinical Advisor (NHS board representative from NHS Forth Valley)

**Penny Leggat**
Public Partner

**Marguerite Robertson**
Public Partner

Supported by:

**Jan Nicolson**
Project Officer

Observed by:

**Kenneth Crosbie**
Inspector

**Jacqueline Macrae**
Head of Quality of Care
Appendix 3 – List of national guidance

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

- **Adults with Incapacity (Scotland) Act 2000** Part 5 – Medical treatment and research

- **Best Practice Statement for Prevention and Management of Pressure Ulcers** (NHS Quality Improvement Scotland, March 2009)

- **Clinical Standards for Food, Fluid and Nutritional Care in Hospitals** (NHS Quality Improvement Scotland, September 2003)

- **Clinical Standards for Older People in Acute Care** (Clinical Standards Board for Scotland, October 2002)

- **Dementia: decisions for dignity** (Mental Welfare Commission, March 2011)


- **National Standards for Clinical Governance and Risk Management** (NHS Quality Improvement Scotland, October 2005)

- **Scottish Intercollegiate Guideline Network (SIGN) Guideline 86 – Management of Patients with Dementia** (SIGN, February 2006)

- **SIGN Guideline 111 – Management of Hip Fracture in Older People** (SIGN, June 2009)

- **Standards of Care for Dementia in Scotland** (Scottish Government, June 2011)
Appendix 4 – Inspection process flow chart

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

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
### Appendix 5 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AMT</td>
<td>abbreviated mental test</td>
</tr>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
</tr>
<tr>
<td>DNACPR</td>
<td>do not attempt cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>HDL</td>
<td>Health Department Letter</td>
</tr>
<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
</tr>
<tr>
<td>ROTAS</td>
<td>Rapid Occupational Therapy Assessment Service</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
</tbody>
</table>
How to contact us

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

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

**Edinburgh Office** | Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB  
**Telephone** 0131 623 4300  
**Email** hcis.chiefinspector@nhs.net

www.healthcareimprovementscotland.org

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