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Background to inspection

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 Healthcare Improvement Scotland’s Care of Older People in Hospital Standards (June 2015).

2. Our inspection process is focused 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. The NHS board visit is then followed up by 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 NHS board teams are given appropriate support 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 the Royal Infirmary of Edinburgh. The report highlights four areas of good practice and 13 areas for improvement.

6. A senior inspector led the team and was responsible for providing advice and guidance, including in relation to the findings. The team was made up of five inspectors and a public partner, with support from a project officer.

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 [http://www.healthcareimprovementscotland.org/OPAH.aspx](http://www.healthcareimprovementscotland.org/OPAH.aspx)
A summary of our inspection

8. This report sets out the findings from our unannounced inspection of the Royal Infirmary of Edinburgh. The Royal Infirmary of Edinburgh is a major acute 1,014 bedded hospital. It has a 24-hour accident and emergency department and provides a full range of medical and surgical services for patients from across Lothian and specialist services for people from across the south east of Scotland and beyond.

9. We carried out the unannounced inspection from Tuesday 30 August to Thursday 1 September 2016 and we inspected the following areas:
   - acute medical unit (AMU) (assessment area)
   - ward 108 (orthopaedic trauma)
   - ward 201 (stroke)
   - ward 202 (medicine for the elderly)
   - ward 203 (medicine for the elderly)
   - ward 207 (general medicine), and
   - ward 208 (general medicine).

10. We also visited the emergency department and ward 104 (medicine for the elderly) to observe breakfast.

11. Before the inspection, we reviewed NHS Lothian’s self-evaluation and gathered information about the Royal Infirmary of Edinburgh from other sources. This included Scotland’s Patient Experience Programme, and other data that relate to the care of older people. We also carried out an NHS board visit to NHS Lothian on 14 April 2015. Based on our review of this information, we focused the inspection on the following outcomes:
   - treating people with compassion, dignity and respect
   - screening and initial assessment
   - person-centred care planning
   - safe and effective care
   - managing the return home
   - leadership and accountability, and
   - communication.

12. During the inspection, we:
   - spoke with staff and used additional tools to gather more information. In all wards, we used a formal observation tool and the mealtime observation tool, where appropriate. We carried out 21 periods of observation and, in each instance, members of our team observed interactions between patients and staff in a set area of the ward for 20 minutes.
   - carried out patient interviews and used patient and carer questionnaires. A key part of our public partner role was to talk about their experience of staying in hospital and listen to what was important to them. We spoke with 29 patients during the inspection. We received completed questionnaires from 44 patients and 13 family members, carers or friends.
• reviewed 30 patient health records to check the care we observed was as described in the care plans. We reviewed 30 patient health records for cognitive impairment; 29 records for food, fluid and nutrition and pressure ulcer care; 28 records for frailty and comprehensive geriatric assessment; and 27 records for falls risk. We also reviewed 30 patient health records for medicines reconciliation and viewed 19 DNACPR forms.

13. We would like to thank NHS Lothian and in particular all staff at the Royal Infirmary of Edinburgh for their assistance during the inspection.

Areas of good practice

14. We noted areas where NHS Lothian was performing well in relation to the care provided to older people in acute hospitals. These include the following.

• Patient mealtimes were well managed and patients were observed to receive appropriate assistance.
• There was evidence of good communication between the hospital and community staff about a patient’s wound management.
• Introduction of the NHS Lothian Care Assurance Standards to support continuous improvements in patient care.
• Establishing a Quality Academy that supports leaders and teams across NHS Lothian to implement quality improvement projects.

Areas for improvement

15. During our inspection we identified 13 areas for improvement, which include the following.

The NHS board must ensure that:

• the electronic patient health record system in place is improved to ensure accurate and accessible patient health records. If this cannot be immediately assured, NHS Lothian must put in place an alternative system in the interim.
• all patient assessments are fully and accurately completed in line with national standards.
• The Malnutrition Universal Screening Tool (MUST) is used to identify height and weight issues.
• patients have person-centred care plans in place for all identified care needs. These should evidence patient and carer involvement and agreement, and be regularly evaluated and updated to reflect changes in the patient’s condition or needs.
• patient flow and capacity is supported by all members of staff, including senior medical staff, and that there is ongoing dialogue and joint working with social care partners to support the safe and effective discharge of patients.

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

16. A full list of the areas of good practice and areas for improvement can be found in Appendices 1 and 2 on pages 29 and 30. 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.
17. 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 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

18. All patients were observed to be treated with dignity and respect. All patients appeared comfortable and well cared for, and were appropriately dressed. The majority of patients were dressed in their own clothes, whilst others were in hospital gowns.

19. All patients interviewed said they had privacy at all times. Curtains were seen to be closed where appropriate and a privacy sign pegged to the outside of the curtain was used to show when care was being delivered. This ensured that other staff knew not to enter at that time. We observed staff either knocking on doors or asking permission to enter where curtains were drawn.

20. We saw that patients had drinks and personal items within reach, as well as hearing aids and walking frames where appropriate. Call buzzers were seen to be in reach of all patients. We heard call buzzers activated during our visit which were answered promptly. Many patients told us that they had not needed to use the buzzer as staff were so attentive and were visible within the bays due to the ward layout.

Patient and staff interactions

21. All interactions observed between patients and staff were positive and no negative or inappropriate language was heard. Patients also told us that staff explained where everything was and how to use it.

22. We saw staff interact on several occasions with a patient who was distressed. The staff clearly knew information about the patient and their family as they used this to provide reassurance and orientation.

23. We saw that patients had their preferred names written on bedside information sheets above their beds or on their wardrobes. Patients told us that they were addressed by their preferred name at all times.

General environment

24. Despite wards being busy, they generally appeared calm and organised. Wards were uncluttered and the main ward corridors were clear allowing patients to see a clear path to walk.

25. We saw clear signage to direct visitors to nursing stations. All wards had the same layout and had a separate nursing station in each designated base area. Some wards had seating areas for patients at different points along the ward corridor to provide a space for patients to use outside the bedroom areas.

26. Wards consisted of single rooms and four-bedded rooms. All rooms had an ensuite shower and toilet. Wards visited had a room available for patients and visitors to use. We saw a small relative’s room on the orthopaedic trauma ward and a physiotherapy gym in the stroke ward. Patients told us that noise levels were not an issue on the ward.

27. We saw dementia design principles being used such as contrasting colours and tones. Handrails were in place in the ward corridors. Word and pictorial signage was in use to identify rooms such as toilets, showers and bedrooms. Patients’ bedrooms and bays were also numbered to make them easier to locate. We saw day and night clocks in use in patient rooms.
Patient and visitor information
28. There was a range of information on display in the wards inspected, for both patients and visitors. This included visiting times, mealtimes, the name of the person responsible for caring for the patients that shift and the name of the nurse in charge.

29. We saw laminated posters on display that detailed activities, such as Artlink, that were taking place within the hospital. This included a ‘book and a blether’ and ‘sunshine opera’. One patient health record that we reviewed showed that they had attended an activity and had stated that they had enjoyed it. Ward 203 also had a poster that stated the days the ‘therapeut’ visited. The senior charge nurse in this ward also told us that there was good support from the chaplaincy service.

Display of patient information
30. Information above the patient’s bed was limited with some only having the patient’s name on display. In other wards more patient information was displayed above the patients’ beds which identified the patient’s status for falls risk, mobility requirements and nutrition information such as ‘nil by mouth’ or if a fluid balance or food record chart was in use.

31. Ward 201 had a large multidisciplinary patient information whiteboard in the doctor’s room. This listed detailed patient information, including multidisciplinary input, estimated dates of discharge and resuscitation status.

Visiting hours
32. Patients told us through interviews that visiting hours suited both them and visitors. Several patients told us that staff were relaxed about the visiting hours and were willing to allow visitors outwith normal hours.

Patient feedback
33. During the inspection, we spoke with 29 patients. 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 was mostly positive.

34. The majority of patients felt their care and treatment were good and that they and their family and carers had been involved and listened to about their care and treatment.
   - ‘(They) have been so kind, they come round all the time.’
   - ‘I’ve been well looked after. Nothing is too much trouble.’
   - ‘Staff are busy but very approachable.’

35. We received 44 completed questionnaires from patients. Of the 44 patients who completed the questionnaire, we received the following responses to preset statements:
   - 41 patients agreed or strongly agreed ‘Staff address me by my preferred name’
   - 39 patients agreed or strongly agreed ‘Staff check on me regularly to ask if I need anything’, and
   - 38 patients agreed or strongly agreed ‘Staff listen to my views about my care’.
Patients also commented that:

- ‘The staff are friendly and inform my family about what is happening with my grand dad while they are caring for him.’
- ‘Care and attention extremely good.’
- ‘Given 4 hours in a room and no one came to see me (only complaint).’

Carer and visitor feedback

We received 13 completed questionnaires. Of the 13 responses to preset statements, we received the following responses:

- all 13 carers and relatives agreed or strongly agreed ‘The ward is a welcoming place’ and ‘staff are friendly and approachable’
- 11 carers and relatives agreed or strongly agreed ‘I know who to speak to if I have questions about the care and treatment of the person I am visiting’, and
- 12 carers and relatives agreed or strongly agreed ‘I feel as involved in the care and treatment of the person I am visiting as I would like to be’.

Relatives and carers also commented that:

- ‘The hospital has been absolutely fantastic in caring for my father. They are helpful, caring and considerate of everyone’s needs. I have always been confident that my Dad is in safe hands.’
- ‘All staff are very helpful and polite.’

Screening and initial assessment

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.

All older people admitted to hospital should have assessments carried out to identify any risks and care needs. This includes identification of frailty and comprehensive geriatric assessments, assessments of cognition, 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

NHS Lothian has recently introduced an electronic patient health record system. During our inspection, we spoke with a number of staff about its use and there were
different levels of knowledge about how to use the electronic system and access the information it contained. We were told that staff had received training, but ward staff could not always demonstrate how to access patients’ previous assessments or results on the electronic system. During the inspection, we could not always see if patients’ initial screenings and assessments, for example MUST and Waterlow, had been accurately completed on admission. We could also not be assured that they were completed within the timeframes indicated within the national standards. We were unable to access all information required, for example previous assessment scores, measurements such as heights and weights, and dates of assessments. This was because of difficulties accessing the system.

41. Risk assessments were located on the electronic patient health record system. Although all staff could access the electronic system, most were unaware of how to locate previous risk assessments. It was not possible to determine how scores had been calculated, therefore we were unable to see whether patient outcomes were improving or not.

42. Due to the electronic health record system in use, we cannot be assured that the care provided was appropriate. For this reason, we are unable to state the numbers of patient assessments correctly completed within the national required timeframes.

Frailty and comprehensive geriatric assessment

43. NHS Lothian states in its self-evaluation that it takes a person-centred approach and considers frailty and not chronological age to be the marker for specialist care. The NHS board states that when older people are admitted to hospital, a frailty screening process is completed. If frailty is identified, comprehensive geriatric assessment will be undertaken either by medical staff or suitably trained nurse practitioners. During our inspection, we reviewed 29 patient health records for frailty and comprehensive geriatric assessment. Of the records reviewed, six were seen to have been completed for frailty and one patient was receiving end of life care where an assessment was not appropriate.

44. We found that:

- two patients had a frailty screen completed and were seen by the frailty team. Their assessments were fully documented within the patients’ health records, along with the plan of care.
- where there were a lack of completed frailty assessments in the health records reviewed, we did see patients receiving input from the elderly care and surgical assessment teams and the frailty team.

Dementia and cognitive impairment

45. NHS Lothian’s self-evaluation states that all patients on admission are to have a cognitive assessment carried out using the 4AT assessment. This is recorded either electronically or on a paper version. Reassessment is required if a patient’s clinical condition changes. We reviewed 30 patient health records for dementia and cognitive impairment. However, as previously stated, due to the limitations of the electronic patient health record system in place, we were unable to confirm when these assessments were completed.

46. Where a patient was identified to have a possible cognitive impairment or delirium, evidence was seen within some of the patient health records that further investigations had been carried out. For example, one patient had a more detailed...
cognitive assessment carried out. However, for another patient who was identified from their initial 4AT as having a possible delirium, there was no further assessment noted.

Nutritional care and hydration

47. Nutritional screening is carried out using MUST. This tool calculates a score to indicate the patient’s risk of malnutrition and should be completed within 24 hours of admission. The Food, Fluid and Nutritional Care Standards, Healthcare Improvement Scotland (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 important to have an accurate weight recorded as it may be required for other assessments, such as pressure ulcer care or to calculate the dosage for certain drugs.

48. Twenty-nine patient health records were reviewed for nutritional care and hydration. We saw that there was nowhere to record the patient’s height or weight on the MUST page of the electronic health record system; these were recorded on a separate observations page within the electronic record. It was unclear whether these heights and weights were measured, recorded or estimated. We found that the majority of patients did not have a usual weight or recent weight loss recorded which is required to calculate an accurate MUST score.

49. We found some examples where MUST screening had been completed outwith the 24 hours required by the national standard, for example:

- one patient’s initial MUST screening was completed 14 days after admission.
- one patient refused to comply with screening on admission. A weight was recorded 15 days after admission but a MUST score was not recorded until 55 days after admission. This was inaccurately scored as medium risk instead of high risk.
- two patients did not have any height or weight measurements recorded but had completed MUST scores recorded. Therefore, we could not see how these MUST scores were calculated or have assurance that they had been accurately completed.

MUST rescreening

50. 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 is identified and appropriate action taken such as referral to a dietitian.

51. Eighteen patients were identified as eligible for MUST rescreening; however, we were unable to review how many of these had been completed due to the limitations of the electronic health record system.

52. There was nowhere to record if repeat weights were measured, reported or estimated on the MUST page. We were also unable to see the actual recorded repeat weight measurements for all patients. Examples of delays in MUST rescreenings included:

- one patient, who had been in hospital for nearly 4 months, only had a MUST screening repeated three times, as viewed on the electronic record. This should have been carried out on a weekly basis.
• one patient’s repeat MUST screening was re-done 14 days after the initial MUST.
• another patient had the MUST screening repeated 12 days later.

Nutritional assessment
53. 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. It should also include a documented oral health status.

54. It is important to know a person’s nutritional preferences as they may lose the ability to communicate to staff what their likes and dislikes 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.

55. Twenty-nine patient health records were reviewed for nutritional assessments. The electronic health record system did not contain a section for likes and dislikes, therefore it did not meet the national standards for food, fluid and nutritional care.

Oral health assessment
56. We reviewed 29 patient health records for oral healthcare assessments: three were paper-based risk assessment bundles and two of these were fully completed. There was no oral health assessment within the electronic health record system, therefore none of the other patients had this completed.

Falls risk assessment
57. There is a falls risk assessment bundle in use in NHS Lothian, consisting of five questions on the electronic record system or a paper version. This is to be completed for all patients on admission. If any of these questions are answered as ‘yes’, then a care plan should be completed. Within NHS Lothian, a ‘rationale for the use of bedrails’ assessment has been incorporated into the new falls bundle and is to be completed on admission for all patients. However, due to the electronic record system in place, we could not confirm how many assessments were completed within the required timeframe.

58. We reviewed twenty-nine patient health records for falls risk. We saw that:

• one patient did not have a falls assessment bundle completed until 9 days after admission
• one patient had no falls assessment bundle completed in either the paper record or on the electronic record system, and
• another patient had a blank falls assessment bundle.

Falls risk reassessment
59. Falls reassessments are to be completed on a weekly basis in NHS Lothian. We were unable to establish how many patients had regularly completed reassessments.

Mobility risk assessment
60. NHS Lothian includes a mobility risk assessment as part of their falls prevention management. We reviewed 23 patient health records for mobility risk assessment but could not establish how many had been completed within 24 hours of admission.
Preventing and managing pressure ulcers

61. NHS Lothian uses an adapted Waterlow pressure area risk assessment tool which is located on the electronic system. This assessment should be carried out within 6 hours of patient admission.

62. We reviewed twenty-nine patient health records for pressure area care. We were unable to establish how many were accurately completed within 6 hours of admission.

63. We were unable to establish some patients' weights, therefore we were unable to verify if Waterlow assessments were correct. We found:
   - one patient's assessment was repeated on transfer of their care
   - a patient who was fully dependent on staff had no assessments carried out, and
   - four patients had the Body Mass Index (BMI) component of the assessment completed, but no weight or height had been recorded, therefore it was unclear how the BMI element of Waterlow was calculated.

Waterlow reassessments

64. NHS Lothian states that Waterlow assessments that are used to assess the integrity of a patient's skin should be completed when a patient's condition changes. However, staff told us that they reassess on a weekly basis. It was unclear how many patients had regular reassessments on the electronic record system.

65. We found that the Waterlow assessments on the electronic record system only recorded the final score, therefore it was not possible to see how each element had been calculated. This meant that where the scores changed, it could not be established what caused the change.

Pain assessment

66. It is important to be able to establish if a patient is in pain. NHS Lothian has no formal pain assessments in use. Patients were asked if they were in pain as part of their care rounding but this did not involve using a formal assessment tool. We found that responses were being completed on every entry on the care rounding sheets, even for times that the patients were sleeping. One patient always had a 'no response' completed, despite being unable to communicate due to an altered conscious level.

67. We saw that there was a place on the patient's observation chart for staff to record a pain score. Although some patients were asked about pain, we found that this was not consistently carried out for all patients and was not always done when observations were recorded.

68. It was unclear how patients who could not communicate, for example those who have had a stroke, were being assessed as there were no non-verbal pain assessments used in any of the wards inspected.

Other risk assessments

69. We saw that no risk assessments had been completed for patients who had alarm bracelets or alarms fitted to their room doors. These are used to alert staff when patients are trying to leave the ward.
Medicines reconciliation

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

71. There was an inconsistent approach to the completion of medicines reconciliation across the wards inspected. Some patients’ health records had a dedicated form completed whilst others referred to a printed GP ‘electronic care summary’ (ECS) sheet.

72. Twenty-four patient health records were reviewed for medicines reconciliation and two were fully completed. Of the records reviewed:

- 22 included patients’ demographics
- 14 included the medicines plan recorded for each medicine such as to continue, withhold or stop
- four included the name and signature of the person completing the form, and
- 18 stated that the form had been reviewed by a pharmacist.

73. In some records reviewed, it could not be easily established when medicines reconciliation had been carried out due to dates not being recorded at the time. There was only evidence of five forms being completed within 24 hours of admission.

Do not attempt cardiopulmonary resuscitation

74. 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 health record.

75. Eighteen DNACPR forms were reviewed during our inspection:

- all 18 included the reason for the form being in place
- all 18 included the date that the form was completed
- 17 were signed by a consultant or senior clinician
- 14 included a review date
- 15 included discussions with the patient or their family, and
• two patient health records documented the reason for the decision not being discussed with the patient or family.

The forms were generally well completed; however, some were not reviewed on transfer of care.

Areas for improvement

1. NHS Lothian must ensure that the electronic patient health record system in place is improved to provide accurate and accessible patient health records. If this cannot be immediately assured, NHS Lothian needs to gain assurance of the improving proficiency in the use of the system.

2. NHS Lothian must ensure that all older people who are being treated in accident and emergency or are admitted to hospital, are accurately assessed within the national standard recommended timescales. This is to include frailty, cognition, nutritional screening and assessment, falls, pressure ulcer care and pain.

3. NHS Lothian must ensure that medicines reconciliation is fully completed within 24 hours of admission.

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

Person-centred care planning

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.

Care planning

76. Care plans are used to advise on care delivery and should show an evaluation of a patient’s care. We saw little evidence of nursing care planning in place for patients. This, combined with the lack of assurance around assessment as previously highlighted, does not provide assurance that care was appropriate.

77. NHS Lothian submitted a risk assessment booklet with its self-evaluation which included care plans and information about asking the patient what was important to them (‘information about me’). However, most of the care plans seen were blank.

Care rounding

78. 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.

Pressure area care

79. NHS Lothian’s care rounding documentation incorporates the SSKIN (skin, surface, keep moving, incontinence and nutrition) bundle. This bundle 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 which reduces the risk of developing pressure damage.
80. We reviewed 30 patient health records and found care rounding charts were in place for all patients. However, of the charts reviewed, although several were seen to be fully completed with no gaps, we also saw charts which were not always fully or correctly completed, for example:

- the prescribed frequency of care rounding, such as 3-hourly, was not always recorded. It was, therefore, unclear if the recorded episodes of care delivery were appropriate to meet the patients’ needs.
- many were not consistently completed over a 24-hour period. There were gaps in recording care delivery, for example one patient’s chart had a gap of 8.5 hours and another patient’s chart had a gap in of 6 hours, despite both patients having 3-hourly frequency of comfort rounding prescribed.
- on occasions, ‘yes’ was continually written on the charts for each entry, even when it was inappropriate, such as catheter care being carried out at every care round, including during the night.
- one care rounding chart was seen to be completed retrospectively. The form had been blank at the time of review but was completed later in the day to include an entry for early morning.

**Oral care provision**

81. We noted that many care rounding charts reviewed had oral hygiene recorded at every entry, for example six times a day. When we asked the senior charge nurses about the accuracy of this, they admitted these entries would not be correct and oral hygiene would not be carried out this often, particularly for more able and independent patients. We also noted that there were no entries of oral care being provided at bedtime.

82. We noted for one patient that speech and language therapists had documented in the health records that mouth care was required every hour, but this was not evidenced hourly on the care rounding sheet.

**Areas for improvement**

5. NHS Lothian must ensure that patients have person-centred care plans in place for all identified care needs, including cognitive impairment, nutritional care, falls and pressure area care. These should evidence patient and carer involvement and agreement and be regularly evaluated and updated to reflect changes in the patient’s condition or needs.

6. NHS Lothian should ensure full and accurate completion of care rounding checklists; the frequency of which should be clearly determined by patients’ assessments and care plans. This should also include oral care.
Safe and effective care

Outcome 5: Cognitive impairment
The patient, with dementia (or cognitive impairment), experiences care that is tailored to meet their individual needs and promotes their mental wellbeing.

Ensuring that:
- care for older people with dementia (or cognitive impairment) meets the Scottish Government Standards of Care for Dementia in Scotland, and
- guidelines on use of medication for the behavioural and psychological symptoms of people with dementia and/or delirium are available to all staff.

Delirium

83. Delirium (sometimes called acute confusional state) is a common, serious condition for older people and is the most common complication of hospitalisation in the elderly population. This medical emergency is often under-recognised and poorly managed. The incidence is also higher in those with a pre-existing cognitive impairment.

84. We saw that where a patient was identified with a possible delirium, it was recognised and documented within the patient health record. We also saw evidence of investigations being carried out (including medication reviews) to identify the cause and to inform treatment of delirium.

Capacity assessments

85. An assessment of capacity to consent to treatment should be carried out where a cognitive impairment has been identified, as this will inform the decision to whether an Adult with Incapacity (AWI) certificate is required.

86. We saw 11 patients’ whose cognitive assessment or physical condition should have prompted an assessment of capacity to consent to treatment. Four patients had this documented within their health records. The 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.

Power of attorney

87. NHS Lothian’s risk assessment booklet, which was submitted as evidence to support its self-evaluation, contained a prompt for staff to ask if a power of attorney or guardian was in place. However, we did not see this included in any of the records reviewed.

88. Five power of attorneys were stated as being in place but we only saw one copy. This patient’s health record clearly recorded the details of the power of attorney and contained a copy of the document. Ward staff had contacted the Office of the Public Guardian to verify the information and to establish if the powers were still held. Of the remaining four, we saw:
- one did not verify the powers held, and
- three patients’ health records stated ‘discussed with power of attorney’, despite it not being documented anywhere else within the records that a power of
attorney was held. There were no contact details recorded and there were no entries found to state that they had been requested.

AWI certificates

89. Eleven AWI certificates were in place and six patient health records recorded the decision for their use. One further AWI certificate should have been in place at the time of inspection, and was later seen to be put in place. Five of the AWI certificates viewed had the nature of incapacity completed and stated the length of time the certificate was to be valid for. For example, one patient had an AWI certificate in place for a timeframe of 3 months. The patient remained in hospital beyond this time and their certificate was reviewed again appropriately.

90. We also saw some examples of poor completion of AWI certificates, for example:

- one AWI certificate was not discussed with the patient's family or power of attorney and did not take into account the patient's long-term conditions.
- one AWI certificate viewed had expired 3 days before our inspection. There was no treatment plan in place. We brought this to the attention of the nursing and medical staff and raised the issue that other interventions were taking place that were not covered on the certificate. The doctor stated that as the patient was not refusing care, they did not need to consider these on the AWI certificate. This did not demonstrate an understanding of obtaining informed consent.

91. We saw that some AWI certificates had accompanying treatment plans in place. Overall, these were too general, rather than having specific interventions listed. Many stated 'general' or 'all medical and nursing care'.

Getting to Know Me

92. ‘Getting to Know Me’ is a document to record information about a person with dementia that will help hospital staff understand the patient better.

93. While we did see some ‘Getting to Know Me’ booklets, these were inconsistently completed by patients or relatives. They did not appear to inform care planning and they were not seen to be in use for patients with a known dementia.

Management of stressed and distressed behaviour

94. During our inspection, we observed some positive engagement between staff and patients who were exhibiting stressed and distressed behaviours. For example, we heard staff speaking with a distressed patient about family members and favourite hobbies; this was seen to have a positive effect on reassuring the patient and easing the distress. The patient had a colouring book that was also being used.

95. We saw behaviour charts for two patients which were used to record when they displayed stressed or distressed behaviour. These included what was happening before the distress, the displayed behaviour, what actions the staff took and the effect of their actions. Whilst some of charts were well completed, this was not consistent on all charts.
Area for improvement

7. NHS Lothian must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. This includes consulting any appointed power of attorney or guardian. When legislation is used, this must be fully documented in the patient health record, including any discussions with the patient or family.

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

96. All wards had access to patient weighing scales that were in working order. These included sitting, standing and hoist scales. One ward only had chair scales, so if a patient was unable to get out of their bed, we were told that the staff would estimate the patient’s weight on admission. Some wards had height sticks but staff told us that they used alternative measures to calculate heights or patients reported their own height.

- During our inspection, we identified an issue with one patient on a ward where there was a significant variation in weights recorded on the electronic record system. No weight was recorded on admission and the patient’s subsequent recorded weights fluctuated over the period of a month. We asked the senior charge nurse to check the accuracy of the scales. We also raised the issue with NHS Lothian and requested a review of the patient’s care and that we be informed of the outcome. Since the inspection, NHS Lothian has carried out a review of the patient’s care and was satisfied that the patient’s care and treatment was not affected by this. However, an action plan has been put in place to address issues identified at the time of carrying out the review.
- One patient did not have an accurate weight recorded, despite this being requested by the dietitian several times. This was due to appropriate scales not being available in the ward.

Dietetic and speech and language therapy cover and referrals

97. Eight patients’ MUST scores should have triggered a referral for dietetic input. Seven of these had a dietetic referral made. A further two referrals were made based on clinical judgement. It was unclear, however, when the referrals were made due to the dates of referrals not being clear on the patient records.

98. We saw comprehensive assessments, treatment plans and advice documented from both the dietitians and speech and language therapists. We saw that regular reviews were also documented. Dietitians had identified where some patient weights had not been obtained and recorded.

99. One patient was referred to the dietitian due to their MUST score and was seen within 2 days. Advice was given on the type of diet and extra snacks needed and a request
that a food record chart be completed. However, further entries by the dietitian showed that the completion of the food chart had not always taken place.

Identifying individual patient nutritional needs
100. Patients’ nutritional needs were written on the whiteboard at the patient’s bedside but this was not used in all wards. Where in place, they noted whether a patient was nil by mouth, diabetic, required a special or texture modified diet or assistance with meals. This was also recorded in the patients’ records.

101. Information was also shared in the ward safety brief and individual ward handover sheets. Some wards were seen to have kitchen whiteboards which highlighted patients who were receiving supplements.

102. We were told that a red tray system was in use. This identifies to staff which patients need assistance with their meal. We saw some red trays in use, but not for all patients who needed assistance. During a mealtime observation in one ward, we saw that a prompt was used when giving out breakfasts to highlight which patients required assistance and a red tray.

Protected mealtimes
103. Protected mealtimes are in place in the hospital to reduce non-essential interruptions during mealtimes. This makes sure that eating and drinking are the focus for patients without unnecessary distractions. All mealtimes observed were seen to be well managed and co-ordinated. All staff were seen to be involved in the management and distribution of meals during our observations and meals were seen to be given out quickly and efficiently.

104. Although not all wards had designated mealtime co-ordinators, all staff knew which bays to take meals to and it was a very smooth process. Meals were served in a timely manner and as separate courses. Water jugs were seen to be freshly replenished before mealtimes and with the exception of one ward, patients were seen to be offered fresh drinks with their meals.

105. Patients were prepared for their meals and hand hygiene offered. This meant staff were not interrupted by having to stop and clear tables when giving out meals. Two wards were seen to have adapted equipment on the wards, such as plate guards and beakers. Ward staff could ask the occupational therapist for other items if required.

Assistance with eating and drinking
106. Patients who needed assistance received this in a timely manner. Staff were seen to open packets and cut up food. Staff were also seen sitting at the patient’s level, engaging with patients and taking their time to assist them.

107. Staff were seen to go back to patients to offer encouragement and check they were managing. We heard staff asking patients whether they had received enough to eat.

 Provision of fluids and snacks
108. Patients were seen to be offered juice or milk with their meals and hot drinks with their breakfast. Patients told us there was a choice of drinks and chilled water was changed at least twice a day; some patients said three times a day. All wards inspected had access to a wide variety of snacks and toast was supplied in the evening. Within the acute medical unit, there were sandwiches available for those patients who were admitted after mealtimes. Staff were seen to be accommodating to patients’ nutritional needs and wishes.
109. Patients we spoke with all felt the food was of a good quality, sufficient variety and choice and appetising. All patients told us that meals were of an acceptable temperature. No patients reported being interrupted during meals and all patients told us they had enough time to prepare for meals, with wipes usually offered. Some comments received from patients included:

- ‘They keep water topped up.’
- ‘Food is great, no problem with meals. Unsure why patients complain about it.’
- ‘Big portions. Feel bad as not that hungry. Enjoyed many meals so far. Not interrupted.’
- ‘Food fine, get what I ordered. No interruptions. Have water filled up.’
- ‘Food is OK, 50/50. Don’t feel I should criticise too much. Drink choices are fine.’

Food record and fluid balance charts

110. Food record charts 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.

111. Eleven patients had a fluid balance chart in place. We found an inconsistent approach to the completion of the charts. None of the 11 charts were fully or accurately completed, for example some did not include the total fluid balances to inform the next day’s care. Some charts only recorded prescribed intravenous fluids and had no other entries for other fluids taken. No charts stated the reason for them being in place.

112. Five patients had a food record chart in place. Two additional patients should have had food record charts in place but these were not seen. None of the charts we reviewed were fully or accurately completed to include all food offered at mealtimes, afternoon and evening snacks, and the amounts actually eaten. For example:

- one patient only had breakfast recorded and none of this had been eaten. No other meals or snacks were seen to be recorded. The following day, there was no morning drink or snack recorded as offered or consumed.
- one patient had only breakfast and evening meal recorded on one day. The following day the chart was blank. The next day, no snacks were recorded. The charts then stopped, despite the patient’s health record stating that day that the patient had lost weight and was on supplements.
- one patient had a lack of food record charts despite two dietetic entries stating that weight had been lost and that food charts should be completed.

Oral nutritional supplements

113. Oral nutritional supplements are prescribed for patients who require additional calories and or nutrients. It is important that patients receive their nutritional supplements to ensure their individual nutritional needs are met. We found issues around the completion of the dietetic prescription charts for oral nutritional supplements. Staff were not recording on the chart that all prescribed supplements were being given to patients. We saw the following approach to the recording of the supplements that patients had been prescribed.
On one ward, one patient’s chart entries were recorded for a 2-day period but then had gaps of 5 days with no entries. Two further days’ charts were then completed, followed by another gap of almost 2 weeks before another chart was seen. On two days when the charts were in place, only the morning oral nutritional supplements were recorded, not the midday or evening supplements. A further day’s chart had a question mark written on the day’s column and another day had no entries recorded to indicate if the supplements had been given at all.

In another ward, gaps were seen in a patient’s chart. One day had all three supplements recorded correctly, but the following 2 days only had two supplements recorded. Then three supplements were recorded again for the following 2 days.

Artificial nutrition

114. 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 gut or by a line into a vein.

115. Of the patient health records reviewed, five patients were receiving artificial nutrition. All five patients had a multidisciplinary assessment carried out and the outcome of the assessments and a proposed action plan were documented in their health records.

116. All five patients had dietetic feeding regimes in the patient health records reviewed. NHS Lothian policy is to record artificial nutrition on the fluid balance charts. No charts were seen to have been fully or accurately recorded with the prescribed feeds and water by nursing staff. We saw:

- one patient had a dietetic prescription chart stating the amount of feed and fluid the patient was to receive. However, on these dates there was no evidence that all of the prescribed feed and water had been given. The second day did not evidence that the prescribed fluids had been given.
- for another patient, feeds and prescribed fluids were recorded for 2 days but it was unclear what the patient had received before this. The dietitian had documented that all food and fluid was to be recorded on the fluid balance chart.

117. As a result, we were, therefore, not assured that the patients who were receiving artificial nutrition were getting the full prescribed amounts of feed and water. These issues were raised with the nurses in charge to highlight that all prescribed feeds and water must be fully recorded for all patients.

Area of good practice

- Patient mealtimes were well managed and patients were observed receiving appropriate assistance.
Areas for improvement

8. NHS Lothian must ensure that all prescribed oral nutritional supplements and artificial feeds are fully and accurately documented for all patients who are receiving them.

9. NHS Lothian must ensure that fluid balance and food record charts are commenced and fully and accurately completed for patients who require them and appropriate action is taken in relation to intake or output as required.

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
118. NHS Lothian has a policy and protocol for the assessment and management of adults with inpatient falls. There was documented evidence within the patient health records reviewed of physiotherapist input to inform the management of falls risk.

119. Patients identified as being at high risk of falls were highlighted on the ward handover and safety brief. Some wards also highlighted the risk of falls at the patient bedside, but this was not evident across all wards we inspected. Patients requiring higher levels of observation were placed in rooms nearer the nurse bases to ensure they were visible to staff. Staff told us that they can access high/low beds for patients at risk of falls.

Post-falls management
120. Of the 28 patient health records we reviewed for falls risk, three patients had fallen whilst in hospital. Three patients had post-falls documentation completed and two had their falls risk assessment updated.

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 NHS Quality Improvement Scotland Best Practice Statement for the 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 bundle within the care rounding document
121. We noted that there was variable completion of the care rounding charts in relation to the elements of pressure area care, for example:

- some entries stated that one patient had red or broken skin but the area of skin this related to was not circled on the chart to identify it.
• another patient had no outcome of skin reviews documented, despite the care plan stating that their skin was red. The patient’s position was stated as being in their chair but their care plan stated that the patient was bedbound.

• another patient had lots of entries recorded as ‘N’ (No) for the visual skin check and ‘-’ written under many of the ‘outcome of skin review’ boxes, therefore essential elements of skin checks had not been carried out and it was unknown what the outcome was as this box was blank.

122. Examples of poor recording of positional checks we saw during our inspection included the following.

• one patient who needed the assistance of two members of staff for repositioning had no care recorded after 1pm on one day. On another day, the care rounding sheet showed that they had been in the same position from 1am to 1pm.

• some entries stated that position had changed since last care round, but all entries on the chart stated the same position, for example ‘B’ for back.

• inconsistent recording of the type of mattress patients were on.

Wound assessment charts

123. Wound assessment charts allow a clear plan of management to be developed to promote wound healing for each patient with a wound.

124. From the patient health records reviewed, two patients were identified as having a pressure ulcer. Both patients had a wound treatment chart in place. The wounds were graded on the electronic record system and were reassessed in line with the plan.

• One patient with a foot dressing was seen to have a wound assessment chart and a clear wound management plan. The wound assessment was seen on the electronic record system which detailed the wound and the dressing regime in place.

• One wound assessment was not fully documented at the initial assessment which was 7 days after admission. It was also difficult to review the previous wound assessments fully to see if the wound was healing.

Tissue viability service

125. Staff told us that they could access the tissue viability service based on clinical need by a telephone referral, although NHS Lothian’s self-evaluation stated it was an online referral system. There is no referral criteria and no specific timeframe for review following referral. We were told that patients were seen promptly and advice could be given over the phone if appropriate.

126. Staff told us that if a patient was admitted with a pressure ulcer, they contact the district nurses for the present treatment plan to follow and only contact the tissue viability nurses if they need advice with managing the pressure ulcer. For pressure ulcers which develop during a hospital stay, tissue viability nurses are only contacted if advice is needed.

127. During our inspection, we saw one patient referred to a tissue viability nurse for review and advice. There was documented evidence of the review and advice given by the tissue viability nurse for staff to follow recorded in the patient’s health record.
Area of good practice

- There was evidence of good communication between the hospital and community staff about a patient’s wound management.

Area for improvement

10. NHS Lothian must ensure SSKIN bundles within the comfort rounding charts are fully and consistently completed.

Care Transitions

Outcome 9: Care transitions
The patient is supported during periods of transition through a co-ordinated, person-centred and multi-agency planning approach and area 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.

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

129. Estimated dates of discharge were not always recorded in the patient’s health records, although some were identified on patient information whiteboards within the doctors’ rooms. However, we did see clear evidence of discharge planning, including good evidence of multidisciplinary input from occupational therapy and physiotherapy, as well as referrals to social work for care packages. There was also clear communication with relatives about plans for discharge.

130. A member of staff from all wards attended the daily huddle to identify the number of admissions and discharges expected that day. A safety huddle is a brief, multidisciplinary, daily meeting to discuss patient flow and any patient safety issues.

131. One ward was seen to have information for patients and relatives about the discharge process on display. This clearly stated what the process was and what they could expect.

Patient flow and capacity

132. Patient boarding is when patients are moved from one ward to another to meet the needs of the service and not the patient’s clinical needs. At the time of our inspection, there were 41 boarded patients into wards within the hospital.

133. Patient flow and capacity is a significant issue within the Royal Infirmary of Edinburgh. At the time of inspection, orthopaedic admissions were being cancelled and patients were being moved to wards outwith their specialty. One of the contributory factors was that there were 63 people who were ready to be discharged from hospital but their discharge was delayed.
134. We met with senior staff who informed us that the reason for these delays was due to lack of provision of home care within Edinburgh City. Senior staff expressed their concerns that the situation may worsen particularly as delayed discharges can become more of a challenge over the winter period. Senior management stated that the hospital is currently functioning on the goodwill of staff.

Area for improvement

11. NHS Lothian should ensure ongoing dialogue and joint working with social work to support the safe and effective discharge of patients.

Skills and accountability

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.

135. NHS Lothian is introducing a system of care called the Care Assurance Standards which ensures that staff are knowledgeable and that all care is evidence based. This system focuses on 13 standards of care such as pressure area care, management and prevention of falls, and food, fluid and nutrition. It involves a system of link nurses, for some of the standards, from each ward who have a more in-depth knowledge of their core topic. They will be providing training for staff on the wards.

136. Some wards had link nurses in place, for example, for tissue viability. Where dementia champions were in place, it was highlighted by the use of a poster naming the person. Wards had a ‘focus of the month’ display board with information and guidance for ward staff on a range of patient care topics. Ward 201 has a permanent OPAH (older people in acute hospitals) information board.

Area of good practice

■ Introduction of the NHS Lothian Care Assurance Standards to support continuous improvements in patient care.

Outcome 11: Leadership & management
The patient is cared for by staff who are led and supported by effective managers and leadership at every level (from line manager to executive team and NHS Board members).

The NHS board is able to demonstrate that there is strong leadership from the Board downwards throughout the whole organisation. The management structure of the NHS board can be clearly articulated and evidence is available to show it is being put into practice at ward level, for the benefit of patients.

137. NHS Lothian states that it is working to ensure a high priority and focus is given to improving the care and treatment it provides and the improvements it makes for older people. This is informed by a number of local strategic plans and national policy.
138. Senior management informed us about the Quality Academy which has a focus on improvement techniques. This is attended by senior clinicians and managers. This has already had an effect on practice in test wards. This drive for improvement should be recognised as a positive step forward.

139. We attended the daily planning and huddles that plan the operational aspects of the hospital. Although these were well attended, we noted that it was mainly senior charge nurses and clinical nurse managers; there were no consultants in attendance.

140. Wards appeared to have good multidisciplinary input, particularly in the stroke and orthopaedic trauma wards, which were all well documented. One senior charge nurse we spoke with stated she felt supported in her role and that there was always someone around to ask for advice or information if needed.

141. Where the senior charge nurses were on duty during the inspection, they demonstrated a clear knowledge of what was happening in their ward. They all engaged with the inspection and welcomed the feedback given. The senior charge nurse in one ward had started a social media page on NHS Lothian's intranet for the ward staff as a way of confidentially communicating and sharing information, for example in relation to revalidation.

Area of good practice
- Establishing a Quality Academy that supports leaders and teams across NHS Lothian to implement quality improvement projects.

Area for improvement

12. NHS Lothian should ensure there is more senior medical staff engagement to support optimal patient flow and capacity.

Communication

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.

142. Patients had a combined medical and nursing admission record, an electronic record and a bedside folder in use.

143. Of the paper health records reviewed, not all documentation was seen to be signed and not all entries were legible, timed or dated. Loose-leaf sheets were seen within the unified records, but did not all contain the patient's details, such as name and hospital number.

Area for improvement

13. NHS Lothian must ensure full and accurate completion of all documentation, whether paper based or electronic.
Appendix 1 – Areas of good practice

Safe and effective care

<table>
<thead>
<tr>
<th>Outcome 6</th>
<th>Patient mealtimes were well managed and patients were observed receiving appropriate assistance (see page 22).</th>
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<table>
<thead>
<tr>
<th>Outcome 8</th>
<th>There was evidence of good communication between the hospital and community staff about a patient’s wound management (see page 24).</th>
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</table>

Skills and accountability

<table>
<thead>
<tr>
<th>Outcome 10</th>
<th>Introduction of the NHS Lothian Care Assurance Standards to support continuous improvements in patient care (see page 26).</th>
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</table>

<table>
<thead>
<tr>
<th>Outcome 11</th>
<th>Establishing a Quality Academy that supports leaders and teams across NHS Lothian to implement quality improvement projects (see page 27).</th>
</tr>
</thead>
</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.

Screening and initial assessment

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>NHS Lothian:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>must ensure that the electronic patient health record system in place is improved to provide accurate and accessible patient health records. If this cannot be immediately assured, NHS Lothian must put in place an alternative system in the interim (see page 15). This is to comply with Care of Older People in Hospital Standards (2015) Standard 4, Criteria 7.1 and 11.1; Food, Fluid and Nutritional Care Standards (2014), Criteria 2.1 and 2.2; and Best Practice Statement for the Prevention and Management of Pressure Ulcers (2009), Section 2.</td>
</tr>
<tr>
<td>2</td>
<td>must ensure that all older people who are being treated in accident and emergency or are admitted to hospital, are accurately assessed within the national standard recommended timescales. This is to include frailty, cognition, nutritional screening and assessment, falls, pressure ulcer care and pain (see page 15). This is to comply with Care of Older People in Hospital Standards (2015) Standard 4, Criteria 7.1 and 11.1; Food, Fluid and Nutritional Care Standards (2014), Criteria 2.1, 2.2 and 2.3; and Best Practice Statement for the Prevention and Management of Pressure Ulcers (2009), Section 2.</td>
</tr>
<tr>
<td>3</td>
<td>must ensure that medicines reconciliation is fully completed within 24 hours of admission (see page 15). This is to comply with Scottish Government Health Directorate, Chief Medical Officer (CMO)(2013)18 and Care of Older People in Hospital (2015), Criterion 6.2.</td>
</tr>
<tr>
<td>4</td>
<td>must ensure that clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR) (see page 15). This is to comply with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy – Decision Making and Communication (Scottish Government, August 2016) and SGHD/CMO(2014)17.</td>
</tr>
</tbody>
</table>
### Person-centred care planning

#### Outcome 2

**NHS Lothian:**

5. must ensure that patients have person-centred care plans in place for all identified care needs, including cognitive impairment, nutritional care, falls and pressure area care. These should evidence patient and carer involvement and agreement and be regularly evaluated and updated to reflect changes in the patient’s condition or needs (see page 16).

This is to comply with Care of Older People in Hospital Standards (2015), Criteria 1.1, 1.4 and 11.2; Food, Fluid and Nutritional Standards, Criterion 2.9; and Best Practice in Pressure Ulcer Prevention (2009), Section 1.

6. should ensure full and accurate completion of care rounding checklists; the frequency of which should be clearly determined by patients’ assessments and care plans. This should also include oral care (see page 16).

This is to comply with Best Practice Statement for Working with Dependent Older People to Achieve Good Oral Health (2005) Section 3; and NHS Education for Scotland Oral Health Improvement: Caring for Smiles (2013).

### Safe and effective care

#### Outcome 5

**NHS Lothian:**

7. must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. This includes consulting any appointed power of attorney or guardian. When legislation is used, this must be fully documented in the patient health record, including any discussions with the patient or family (see page 18).

This is to comply with Adults with Incapacity (AWI) (Scotland) Act 2000, part 5 – Medical Treatment and Research; and the Care of Older People in Hospital Standards (2015), Criteria 3.4 and 3.5.

#### Outcome 6

**NHS Lothian:**

8. must ensure that all prescribed oral nutritional supplements and artificial feeds are fully and accurately documented for all patients who are receiving them (see page 22).

This is to comply with Complex Nutritional Care Standards (2015), Criteria 3.4 and 3.5.

9. must ensure that fluid balance and food record charts are commenced and fully 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 Food, Fluid and Nutritional Care Standards (2014), Criteria 2.5 and 4.1g.
### Outcome 8

**NHS Lothian:**

| 10  | must ensure that SSKIN bundles within the comfort rounding charts are consistently and accurately completed to ensure that the frequency of repositioning is prescribed and that the result of skin inspection and any changes made to the repositioning regime are documented. The information gained from each element should be used to inform other assessments to ensure appropriate care planning and delivery (see page 24). |

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

### Care transitions

**Outcome 9**

**NHS Lothian:**

| 11  | should ensure ongoing dialogue and joint working with social work to support the safe and effective discharge of patients (see page 25). |

This is to comply with Care of Older People in Hospital Standards (2015), Standard 15.

### Skills and accountability

**Outcome 11**

**NHS Lothian:**

| 12  | should ensure there is more senior medical staff engagement to support optimal patient flow and capacity (see page 27). |

### Communication

**Outcome 12**

**NHS Lothian:**

| 13  | must ensure full and accurate completion of all documentation, whether paper based or electronic (see page 27). |

This is to comply with The Code, Nursing and Midwifery Council (2015), section 10.4, and the Generic Standards of Record Keeping, Royal College of Physicians (2009).
Appendix 3 – List of national guidance

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

- Best Practice Statement for 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)
- 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

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

Before inspection
- Healthcare Improvement Scotland issues self-evaluation framework to NHS boards

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
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

www.healthcareimprovementscotland.org

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