

Care for Older People in Acute Hospitals

Six-monthly report (February–July 2012)

October 2012





Strategic oversight

On Monday 6 June 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a new programme of inspections. We were asked to carry out these inspections because of our experience of inspecting acute hospitals throughout NHSScotland.

The aim of these inspections is to provide assurance that the care of older people in acute hospitals is of a high standard and to encourage improvement where it is needed.

A regional inspector leads a team of three associate inspectors who carry out each inspection. A project officer and an administrative officer provide project management support. Public partners also join us on inspections to speak with patients and make sure their views are heard.

In the first instance, the inspections include some, or all, of the following key areas:

- treating older people with compassion, dignity and respect
- · dementia and cognitive impairment
- · falls prevention and management
- · nutritional care and hydration, and
- preventing and managing pressure ulcers.

The inspection process

Following the announcement by the Cabinet Secretary for Health, Wellbeing and Cities Strategy, we began developing a methodology for the inspection of the care of older people in acute hospitals. To do this, we consulted with a number of stakeholders including:

- Healthcare Improvement Scotland colleagues
- · NHS staff
- · members of the public
- · professional and voluntary organisations, and
- Scottish Government.

We tried and tested our methodology through a series of pilot inspections in NHS boards that had volunteered to be involved. After each pilot inspection, we reviewed and refined our methodology and inspection tools to be more relevant and appropriate for our inspections. Through this, we were also able to learn what the key issues were for the care of older people in acute hospitals. This led to our focus on the five key areas listed above.

When we were ready to use our methodology, we prioritised hospitals against a range of indicators and created a schedule of inspections. We then asked NHS boards to complete a self-assessment. This enabled them to establish their own performance against the key issues and to start proactive improvement work. The information in the self-assessment submitted to us also informs inspections and allows us to identify the key areas to focus on during inspections.

We then undertake a 3-day inspection to confirm statements in the self-assessment. We check that the policies and procedures are being translated into practice at the point of care and gather evidence on performance and risk. As the inspections are short and only cover a sample of wards, they provide a limited snapshot of what is happening in the hospital. We observe the care provided to older people to make sure that patients are treated with compassion, dignity and respect. We also review patient health records to make sure that assessments are being completed and care plans are being developed. During the first 6 months of inspection, we reviewed 308 patient health records. Of these:

- · 237 were reviewed for dementia and cognitive impairment
- · 27 for falls prevention and management
- · 142 for nutritional care and hydration, and
- 119 for preventing and managing pressure ulcers.

We carry out patient and carer surveys and our public partners speak with patients and their visitors and carers. These provide patients with the opportunity to tell us anonymously about the care they have received. In total, we carried out 184 interviews and received 455 patient questionnaires and 125 questionnaires from family members, carers or friends. In general, patients and their visitors were positive about the care older people received.

- 'My mother has been given superb care. Staff could not have been more helpful, either in their care or in their attention to her relative's concerns. Doctors and nurses have been available to provide information and answer questions. My mother has always been very conscious of her dignity and everyone concerned with her care has been exemplary in maintaining this.'
- 'Doctors and nursing staff treated me with respect and were exceptional in every respect, nothing is too much trouble and they go above and beyond the call of duty in everything they do.'
- · 'Care and attention has been first class. Nothing has been any bother. Food variable but in the main good. Staff seem caring, although very busy environment.'

However, some patients and visitors had concerns.

- 'Communication and information is the most difficult aspect for the relatives of an elderly person – I do not have confidence that staff know what my mother's needs are.'
- 'Though I am elderly I have no problems with personal hygiene. So it would be helpful [for] other patients like me [if] there was a walk in shower facility.'
- 'Nursing staff are obviously understaffed at various times and this affects the care they are able to give.'

We carry out both announced and unannounced inspections. We give NHS boards, 4 weeks' notice of announced inspection, while no notice is given for an unannounced inspection. Unannounced inspections allow us to see things as they are and lessen the stresses and anxiety felt by staff in preparing for an inspection. Announced inspections allow us to meet with senior members of staff to find out what should be happening within the hospital.

Following inspections, we publish reports based on inspection findings. These reports make sure that learning and best practice is shared across hospitals and NHS

boards. NHS boards then develop an improvement action plan to address the areas we identified for improvement and we monitor progress against this.

Key findings

Areas of strength

Inspectors may gather strong evidence that an NHS board is doing well in some practices, ways of working or outcomes for patients. We report these as an area of strength.

In the majority of observations we made, staff treated older people with compassion, dignity and respect. Patient and relative feedback through interviews and questionnaires also showed they were highly satisfied with the care patients received.

We noted that many hospitals had started to make improvements to the ward and hospital environments to make them more suitable for patients with dementia and cognitive impairment. This included improved signage for patients and visitors, particularly for toilets and showers.

We also found that some NHS boards have worked towards setting up specialised services for patients with cognitive impairment. Some NHS boards have set up older people's psychiatric liaison teams. These teams liaise with other services that may need to care for patients with cognitive impairment to allow a quicker discharge and better care planning. We also saw funding from Alzheimer's Scotland help appoint specialist nurse consultants to develop dementia care in NHS boards.

NHS boards have also adopted the Dementia Champions' Programme. The programme helps to make sure that staff have the training they need to improve the experience, care, treatment and outcomes for people with dementia.

When asked about food in hospitals, the majority of patients told us that they were happy with the quality of food and the choices available. In one NHS board, we found there was a particularly good working relationship between ward staff and the kitchen. Ward staff are able to tell the kitchen about new patients arriving on the ward after orders for food have been taken and are able to request meals up to 7.30pm. As a result, patients have better access to food and are more likely to receive the food they want.

Areas for improvement

Areas for improvement mean that an NHS board is not meeting recognised standards or following best practice, and we are concerned about the impact this is having on the patients using the hospital. Areas for continuing improvement are improvements that the NHS board has already identified and started to act on.

During our first 6 months of inspecting, we found that the care delivered to patients was not always person-centred. This was evident in relation to treating patients with compassion, dignity and respect. Medical staff did not always comply with do not attempt cardiopulmonary resuscitation (DNACPR) national guidance on treatment and care for patients. Staff did not always consider the patient's privacy and dignity when discussing personal issues and what was wrong with them at the patient's bedside. We heard some staff using inappropriate language when talking about older people in hospitals.

We also found that assessment and care planning were not always person-centred or effective. In relation to assessment, we found that:

- older people treated in accident and emergency or admitted to hospital were not always assessed for cognitive impairment (6 out of 8 hospitals)
- patients, identified as having a potential cognitive impairment, did not always have their capacity to consent to treatment assessed (4 out of 8 hospitals), and
- patients did not always have nutritional screening carried out on admission or on an ongoing basis (4 out of 4 hospitals).

As a result of this, we found that care plans were not always person-centred or effective.

- Patients, identified as having a cognitive impairment, did not always have a care plan in place to identify their specific needs and how staff will meet these (7 out of 8 hospitals).
- Patients did not always have a nutritional care plan developed, implemented or evaluated (4 out of 4 hospitals).
- Patients, identified as 'at risk' of developing pressure ulcers, did not always have care plans in place to identify their specific needs and how staff will meet these (4 out of 4 hospitals).

This meant that the treatment patients received was not always effective and they did not always have access to the most appropriate treatments, interventions, support and services.

- Patients with dementia did not always have access to a range of activities and stimuli to keep them active and maintain their current level of functioning (4 out of 8 hospitals).
- There were no systems in place to monitor the number of bed or ward moves for patients with dementia (6 out of 8 hospitals).
- Patients were not always provided with adapted equipment and utensils to help with eating and drinking when they needed them (3 out of 4 hospitals).
- Staff did not always care for patients, identified as at risk of developing pressure ulcers, with the appropriate pressure relieving equipment (4 out of 4 hospitals).

Some of these areas of improvement reflect what is happening at a strategic level and how on the care delivered on the ward is impacted. We also found some isolated instances within specific NHS boards that were seen as reflective of the NHS board as a whole. As these were isolated instances, they are not reported here.

NHS boards in Scotland should:

- ensure the legal and ethical practice of staff acts to safeguard the best interests of patients with dementia and cognitive impairment, their families and carers.
- ensure staff understand and consistently apply the Adults with Incapacity legislation.
- draw on good practice to ensure hospital wards and departments are dementia friendly, and use adapted equipment, activities and stimuli for people with dementia and cognitive impairment.

- review their care planning and record-keeping to ensure patient records are complete, accurately reflect the details of care planned and provided to allow continuity of care between staff and promote high standards of care.
- ensure that medical staff at all grades have access to and complete training on DNACPR national policy on an annual basis.

Continuing improvement

The action plans developed by NHS boards following our inspections should help inform and promote improvement in the care of older people in acute hospitals. Sixteen weeks after an inspection, we ask NHS boards to submit an updated action plan to show what improvements they have made. If it is appropriate, we will carry out a follow-up inspection to that hospital to check on improvements. As we continue to carry out more inspections, we will revisit the hospitals we have already inspected to make sure that we inspect all topics in all NHS boards.

As the inspection programme is still relatively new, we are yet to see marked changes in the care for older people in acute hospitals. However, we have been able to see how some improvements are being made through NHS boards sharing learning from inspection, whether through discussions at a national level or through reading other inspection reports. This has led to an increased awareness of some of the issues facing the care of older people in acute hospitals. However, we are still finding that some of the issues that appear on the surface to be the easiest to resolve are most commonly overlooked and solutions harder to find.

We have also found that there is greater awareness of the care of older people in acute hospitals as a distinct area of focus. This has led to staff being more aware of the need for a different approach when caring for older people. It has also led to the development of closer working relationships between ourselves, other colleagues in Healthcare Improvement Scotland, Scottish Government and NHS boards to promote improvement. Improvement programmes are being set up to allow NHS boards to use the learning they take from inspections to make real improvements in the care of older people in acute hospitals.

A key area of focus, as we move forward, are the values and behaviours that determine how older people are cared for in acute hospitals. During our inspections, we have found a number of instances that compromised or did not consider patient dignity. This was most clear in the language sometimes used when discussing the care of older people. We found examples of patients referred to as 'feeders' and 'wanderers'. Patients were also described as needing 'fed' or 'toileted'. We also found that some patients were addressed in a child-like manner and words commonly associated with childhood, such as 'cot sides', were used to describe their care. To address this issue, we will follow up on this in our future inspections and our improvement work.

Next steps

As we continue our inspection programme, we are aware we need to review and assess the programme's impact and effectiveness on an ongoing basis. Over the coming months, we will take the learning we have from our first 6 months of inspection and use this to refine our methodology. We will also work to create a stronger working relationship between ourselves and NHS boards to make inspection a meaningful part of informing improvements in the care of older people in acute hospitals.

We will produce another report in 6 months' time.

lan Smith Acting Chief Inspector

October 2012

Appendix 1 – The hospitals we inspected

Western Infirmary NHS Greater Glasgow and Clyde	Tuesday 21 – Thursday 23 February 2012
Hairmyres General Hospital NHS Lanarkshire	Monday 5 – Tuesday 6 March 2012
Royal Alexandra Hospital NHS Greater Glasgow and Clyde	Wednesday 14 – Thursday 15 March 2012
Western General Hospital NHS Lothian	Wednesday 11 – Friday 13 April 2012
Glasgow Royal Infirmary NHS Greater Glasgow and Clyde	Wednesday 2 – Friday 4 May 2012
Wishaw General Hospital NHS Lanarkshire	Monday 28 – Wednesday 30 May 2012
Monklands District General Hospital NHS Lanarkshire	Monday 25 – Wednesday 27 June 2012
Borders General Hospital NHS Borders	Tuesday 17 – Thursday 19 July 2012

How to contact us

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

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

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Email hcis.chiefinspector@nhs.net



www.healthcareimprovementscotland.org

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







