Unannounced Inspection Report – Care of Older People in Acute Hospitals

Stracathro Hospital
NHS Tayside

21-23 January 2020

This report is embargoed until 10.00am on Wednesday 1 April 2020
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**Background**

1. In June 2011, the Cabinet Secretary for Health, Wellbeing and Cities Strategy announced that Healthcare Improvement Scotland would carry out a new programme of inspections. These inspections are to provide assurance that the care of older people in acute hospitals is of a high standard. We measure NHS boards against a range of standards, best practice statements and other national documents relevant to the care of older people in acute hospitals, including the Care of Older People in Hospital Standards (Healthcare Improvement Scotland, June 2015).

2. Our inspections focus on the three national quality ambitions for NHSScotland, which aim to ensure that all care is person-centred, safe and effective. We are working closely with improvement colleagues in Healthcare Improvement Scotland to ensure that we appropriately support NHS board teams to deliver improvements locally and to share and learn from others.

3. 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**

4. This report sets out the findings from our unannounced inspection to Stracathro Hospital, NHS Tayside. The report highlights one area of good practice and eight areas for improvement.

5. The team was made up of three inspectors and a public partner. An inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached.

6. The flow chart in Appendix 4 summarises our inspection process. More information about Healthcare Improvement Scotland, our inspections, methodology and inspection tools can be found at www.healthcareimprovementscotland.org/OPAH.
A summary of our inspection

7. Stracathro Hospital is a general hospital in Angus. It has 40 beds and provides services including outpatients, stroke rehabilitation and medicine for the elderly assessment and rehabilitation. These services are the responsibility of Angus Health and Social Care Partnership.

8. Stracathro Regional Treatment Centre (SRTC), an acute elective surgical unit, is located within the grounds, as well as the psychiatry of old age unit. The SRTC caters for patients from Grampian, Tayside and Fife NHS board areas and is part of acute services in NHS Tayside.

9. We carried out an unannounced inspection to Stracathro Hospital from Tuesday 21 to Thursday 23 January 2020 and we inspected the following areas:
   - surgical
   - stroke, and
   - ward 2 (medical).

10. Before the inspection, we review a range of information, including a report provided by our data measurement and business intelligence team. The report includes data publically available such as NHS National Scotland Services Scotland publications and reporting platforms and results from the inpatient experience survey. We will also review previous inspection reports and action plans. Based on our review of this information, we focused the inspection on the following outcomes:
   - treating older people with compassion, dignity and respect
   - screening and initial assessment for food, fluid and nutrition and pressure area care
   - person-centred care planning for food, fluid and nutrition and pressure area care
   - food, fluid and nutrition
   - pressure area care, and
   - communication.

11. 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 a mealtime observation tool, where appropriate. We carried out three 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 the public partner role is to talk with patients about their experience of staying in hospital and listen to what is important to them. We spoke with nine patients during this inspection. We received completed questionnaires from seven patients and four family members, carers or friends.
- reviewed 12 patient health records to check the care we observed was as described in the care plans. We reviewed all patient health records for food, fluid and nutrition and pressure ulcer care.

12. We would like to thank NHS Tayside and in particular all staff at Stracathro Hospital for their assistance during the inspection.

Key messages

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

- Patients we spoke with were positive about the care they received during their stay.
- Patient mealtimes were well co-ordinated and managed.
- Not all assessments were completed within the required national timeframe.
- We saw two different versions of the core data set booklet in use. Staff were not always able to record all the information required to evidence the time and date that assessments had been completed.
- Person-centred care plans were not in place for all identified care needs.

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

14. This inspection resulted in one area of good practice and eight areas for improvement. A full list of the areas of good practice and areas for improvement can be found in Appendices 1 and 2, respectively on pages 23 and 24. We expect NHS Tayside to address all the areas for improvement. The NHS board must prioritise those areas where improvement is required to meet a national standard.

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

Treating older people with compassion, dignity and respect

16. During our inspection, we saw staff treating all patients with dignity and respect. All patients appeared comfortable and were dressed appropriately. We saw that patients had call bells, fluids and personal items within reach, when appropriate. When call bells were heard, they were answered promptly.

17. Patients were cared for in either single-sex bays or single rooms. Toilets and bathrooms were located in the main ward area. We saw staff maintained patients’ privacy at all times by closing doors or drawing curtains when delivering care. Wards were spacious and well lit with corridors generally free of equipment to ensure a clear walkway for patients.

18. We saw staff enabled patients to speak with relatives or friends by taking the phone to the patient bedside when calls were received.

Patient and staff interactions

19. We saw staff addressed patients by their preferred name and interactions between patients and staff were positive. We did not hear any inappropriate or negative language.

Display of patient information

20. Information displayed above patient’s bedside was minimal and risk-based. This included the patient’s name, consultant, any modified diet, fluid information and mobility information.

Patient and carer feedback

21. During our inspection, we spoke with nine 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 included the following:

- The majority of the patients interviewed were very happy with the care and treatment that they were receiving, and they felt involved in the decisions about their care and treatment.

- Patients were confident that, where they wished, their relatives or carers were also being kept informed of what was happening. One patient commented that things were explained in an understandable way.
• Patients felt that staff answered call bells as quickly as they could, but staff popped in and out all the time anyway. Patients commented that the staff were all very approachable.
• All patients told us they were happy with the privacy given. Bedside curtains were closed when appropriate, and staff asked permission before entering.

22. Patients also commented:
• ‘Can’t fault the staff.’
• ‘Staff are perfect.’
• ‘My fears and anxieties have been allayed by all the hospital staff I have encountered.’

23. We received seven completed patient questionnaires that included the following responses to preset statements:
• All patients agreed or strongly agreed that: ‘Staff treat me and my belongings with consideration and respect.’
• All patients agreed or strongly agreed that: ‘Staff check on me regularly to ask if I need anything.’
• All patients agreed or strongly agreed that: ‘Staff explain my care and treatment in a way I understand.’
• All patients agreed or strongly agreed that: ‘I get help with washing, dressing and personal care if I need it.’

24. Patients also commented that:
• I was extremely anxious about my admission and treatment and aftercare, but my fears and anxieties have been eased by all the hospital staff I have encountered. I can’t speak highly enough about this experience.’
• ‘In hospital for a full knee replacement has been very good. I have found all the staff lovely and friendly and informative and made me feel at ease and relaxed. This has not always been my experience. I feel that they have contributed to making my experience as good as it could be.’
• ‘Cheerful happy staff. Have made me feel respected and well cared for.’

25. We received four completed questionnaires from carers and visitors that included the following responses to preset statements:
• All visitors agreed or strongly agreed that: ‘I have the option of being able to continue to provide care for the person I am visiting (for example, assisting at mealtimes), if I wish to do so.’
• All visitors agreed or strongly agreed that: ‘The ward is a welcoming place.’
• All visitors agreed or strongly agreed that: ‘Staff are friendly and approachable.’

26. One carer/visitor commented that: ‘The staff are very good and helpful. They have a lot of work to do.’

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. 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.

27. All older people admitted to hospital should have assessments carried out to identify any risks and care needs. This should include assessments of nutritional state 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.

28. NHS Tayside use a core data set booklet for all patients requiring an inpatient stay of over 24 hours. We saw different two different versions of the core data set booklet in use. We noted that there were differences between the two versions which meant that staff were not always able to record all the information required to evidence when some assessments had been completed, or by whom.

29. The core data set booklet includes a plan of patient care and evaluation which should be completed for all amber and red problems from the traffic light system. NHS Tayside user guidance states that: the initial risk assessment of the patients’ needs using the traffic light assessment (and mandatory
assessments) should lead to an individualised plan of care which should be written in the ongoing plan of care and evaluation record.

30. In the medical and stroke wards, patients are generally transferred from other hospitals. Therefore, a transfer checklist and a repeat admission assessment booklet are also used to enable staff to repeat assessments on transfer. These did not however contain the nutritional assessment, including MUST.

Nutritional care and hydration

31. Nutritional screening is carried out using the Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. 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 also important to have an accurate weight recorded as it may be required for other assessments or to calculate the dosage for certain drugs.

32. Of the 12 patient health records reviewed for MUST screening, 11 patients should have had this carried. However, only four patients had this accurately completed within 24 hours of admission. We found the following.

- In two patient health records, it was not stated how the patients’ heights had been measured despite there being a place to record if the measure is actual, reported or estimated.
- In one patient health record, the patient’s usual weight or any recent weight loss was not recorded.
- One patient’s MUST score was incorrectly calculated on transfer from another hospital. Had this been calculated correctly, it would have triggered a dietetic referral.
- In one patient health record, it was unclear when the MUST was completed as there was no place for staff to record this information.

33. We also saw that two patients admitted to the surgical ward had their MUST screening carried out at the pre-assessment clinic, which was a number of weeks prior to admission. We saw that one of these was only partially completed. Staff told us that they had been told by senior managers that they did not need to re-weigh the patient or repeat the screening on admission if the pre-assessment had taken place within the last 6 months.

MUST rescreening
34. 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.

35. Of the five patients who required MUST rescreening, three patients had this accurately carried out within the required timeframe. We found that one patient’s MUST rescreening continued to be inaccurately scored due to the initial MUST screening being miscalculated.

36. In two wards, staff that we spoke with told us that patients are all weighed on set days of the week, rather than on the actual date that their MUST rescreening is due. This means that potentially some are completed outwith the weekly timeframe.

Nutritional assessment

37. 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.

38. It is important to know a person’s nutritional preferences as they may lose the ability to communicate to staff what their preferences are. Where a person has a known cognitive impairment, this information may be obtained from the ‘Getting to Know Me’ document, family members or those who know the patient well.

39. Of the 12 patient health records reviewed, 11 patients should have had a nutritional assessment completed. Four patients had a nutritional assessment accurately completed within 24 hours of admission. We saw that:
   - Two patient’s nutritional assessments were done at pre-assessment, which was one month and 12 weeks before admission.
   - One patient’s nutritional assessment was only partially completed.
   - One patient’s nutritional assessment was blank.

40. However, due to the constraints of the documentation in use, we could not evidence the time that the majority of the assessments were completed.

Oral healthcare assessment/screening

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

42. The nutritional assessment in use includes a section for staff to record if a patient has poor oral health. The section also includes other criteria such as unable to take oral intake or problems swallowing. However, the section does not evidence that lips, oral soft tissues and teeth are being checked in line with

43. Of the 12 patient health records reviewed, seven patients had an initial oral health screening completed. We found the following.

- In four patient health records reviewed, the oral health section was not dated, so we could not be assured that they were completed within 24 hours of admission.
- One patient’s oral health section was ticked ‘yes’, however, it was not clear what element this related to.
- One patient’s oral health section was blank as the nutritional assessment had not been completed.

44. All patients should have ongoing nutritional assessment using the traffic light system. We saw that this was generally completed.

Preventing and managing pressure ulcers

45. NHS Tayside uses a Preliminary Pressure Ulcer Risk Assessment (PPURA) to assess risk of pressure ulcers. This assessment should be carried out within 8 hours of patient admission.

46. Of the 12 patient health records reviewed, eight patients had a PPURA completed within 8 hours of admission. We found the following.

- One patient’s PPURA was completed at the pre-assessment clinic prior to the patient’s admission. This was not reassessed on admission for surgery.
- One patient did not have a PPURA completed when it was identified that they would require to stay in overnight following surgery.
- One patient’s PPURA was not dated.
- One patient’s PPURA was only partially completed.

PPURA reassessments

47. The majority of patients had ongoing assessment completed using the traffic light system.

Area for improvement

1. NHS Tayside must ensure that all older people who are admitted to hospital are accurately assessed within the national standard recommended timescales for nutritional screening (including MUST and oral health), and pressure ulcer prevention. There must be evidence of
reassessment where required. This includes patients who are initially assessed at pre assessment clinics prior to admission for surgery.

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

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

49. We reviewed patient care plans for food, fluid and nutrition and pressure ulcer prevention.

50. The person who performs the care or treatment for the patient should document in the patient’s health record, what has taken place and the patient’s understanding of their pathway of care, including any conversations with the patient or their relatives.

51. We saw that MUST guidance and pressure ulcer prevention treatment plans were in use however, we did not see any person-centred care plans in place or evidence of patients being involved in their care and treatment plans. For example, we saw one patient needed assistance with various tasks due to having a temporary disability. There were no care plans in place to guide staff on what care the patient required.

Care Rounding

52. NHS Tayside uses a care round sheet for recording patient care delivery at the bedside. The majority of patients had this in place.

53. The care round sheet should be completed by recording a tick, ‘N/A’ or ‘I’ (intervention). If an intervention was recorded on the care round sheet as being required, the details of the actual intervention should be recorded in the patient’s notes.

54. During our inspection, we found the care rounding sheets were completed using ticks. However, it was not always clear what aspect of care had been delivered due to several elements within one box. The frequency of care was also not always documented.
Areas for improvement

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

3. NHS Tayside should ensure that care rounding documentation is fully and accurately completed to reflect the care delivered and that the implementation of care rounding is supported by adequate individualised care planning and evaluation of the patient’s care.

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

55. Across all the wards inspected, staff had access to patient weighing equipment that included: a hoist with built in scales, stand on and wheelchair scales.

56. Not all the equipment we inspected had evidence of calibration within the expected timeframes. We raised this with nursing staff who told us they would report this to the estates department. We were told at the discussion session when we raised this that the calibration of weighing equipment is part of a rolling programme co-ordinated by the estates department.

Dietetic and speech and language therapy cover and referrals

57. Staff we spoke with told us that dietetic and speech and language therapy services are onsite. Referrals could be made by telephone or in paper form and that response times for both services were generally good.

58. During our inspection, we saw four patients who required a dietetic referral. Of these, two patients were referred for nutritional support due to problems with swallowing.

59. We also found that one patient should have had a referral to the dietitian however, the MUST score was incorrectly calculated and therefore failed to trigger the process. We raised this with staff and were told that the dietitian had spoken to the patient.
60. All patients that were seen by a dietitian and speech and language therapist had evidence of assessment being carried out with a clearly documented plan and timescale for review.

Identifying individual patient nutritional needs

61. Nurses stated patient nutritional needs were highlighted at the ward safety brief, shift handover and written on their handover sheet. Two wards had a nutritional board in place which detailed special diets and which patients were on food or fluid charts.

62. On patient’s bedside boards, guidance from the speech and language therapist was displayed for those patients who were on modified diet and fluids. We were also told that these boards would be used to alert staff if a patient was nil by mouth.

Protected mealtimes

63. Protected mealtimes are used to reduce non-essential interruptions during mealtimes. This makes sure that eating and drinking are the focus for patients without unnecessary distractions.

64. During our inspection, we observed two mealtimes. We noted that mealtimes were well managed and coordinated with no interruptions observed. Some patients were able to eat meals in the dining room which provided the opportunity for social interaction. There was good communication between the two members of staff and one of which was always present in the dining area. Staff allowed patients time to finish their meals.

65. Courses were served separately to patients to ensure that food remained hot. As meals are provided as a bulk supply, staff were able to offer different portion sizes depending on patient’s preference.

66. We did not see patients routinely being offered hand hygiene prior to the mealtime. We acknowledge this may have been carried out prior to leaving their bedroom or on route to the dining room.

67. Patients were provided with protective aprons, but this did not appear to be done in a person-centred way. The majority of patients were given an apron without being asked.

68. Patients were encouraged to be independent, but were given assistance when required. We saw the use of assistive equipment and adapted cutlery.

69. We saw patients who were identified as requiring special or modified diets on the nutritional boards, were seen to receive these.

70. Patients we spoke with generally thought that the food was good in terms of choice, quality, quantity, taste and temperature. Most were also were happy
that they had received what had been ordered, although two patients said that there were occasions when they had not.

Patients we spoke with in the surgical ward had generally just been admitted or had only been in for a short time. This meant that it was not possible for them to choose meals, however, they told us that they were content with what they had been given.

Provision of fluids and snacks

Across all wards inspected, we saw a wide range of fluids and snacks available to patients throughout their stay, these included:

- water, diluting juice, milk, tea and coffee, and
- bread, toast, sandwiches, yoghurts, biscuits and cereal.

Food record and fluid balance charts

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

In one ward, we saw that food record charts and fluid balance charts were kept in the dining area to ensure that they were completed after meals. In the other wards, these were kept at the patient bedside.

Food record charts

During our inspection, three patients had food record charts in place. We found these to be poorly completed as they were only completed for the main meals and did not record any snacks or drinks offered or taken outwith these times. We also saw that some food record charts:

- did not record the amount offered
- were left blank for some meals, and
- did not reflect when the patient was nil by mouth.

Fluid balance charts

During our inspection, we saw three patients with fluid balance charts in place. Although some charts were fairly well completed for intake and output, this was not consistent on all fluid balance charts seen. Some charts did not record output or overall fluid balance totals.

In NHS Tayside, the fluid balance chart has a place to record the fluid goal or fluid restriction for the day. Where this was completed, it was not stated if the amount was a goal or a restriction. Many did not state the reason for the chart being in place, or the patient’s current weight, despite having a place to record
this information. It was also not evidenced that staff considered the previous days overall fluid balance when planning care needs.

Artificial nutrition

78. 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.

79. During our inspection, we saw one patient who was receiving artificial nutrition. We saw evidence of both the dietitian and the speech and language therapist being involved in the patient’s nutritional care. The decision for artificial feeding was documented within the patient’s health record.

80. The patient had a couple of nasogastric feeding (NG) tubes inserted and we saw that a nasal retention device was in place. A nasal retention device provides a means of securing a nasogastric feeding tube in position to prevent accidental or intentional removal by the patient. We did not see any evidence of the NHS Tayside insertion checklist being used, however, a sticker which had some elements of the checklist had been completed and inserted into the notes. Neither of the stickers used recorded that the patient had consented to the procedure, or that the tube had been marked at the nostril in accordance with NHS Tayside policy. In addition, we found no documentation regarding the insertion or checking of the nasal retention device, which was seen to be in place at the time of inspection.

81. The patient’s dietetic feeding regime clearly stated the type of feed, the prescribed rate, and volume to be given. It also stated the amount and times of water flushes to be given. Overall, the nursing documentation for the care and management of the NG tube and feed was poor.

82. We saw a poor quality photocopy of the NHS Tayside enteral feeding administration chart in use. This allows staff to record the pH of aspirate, type, volume and rate of feed to be given along with start and end time and the volume of flushes given. Staff recorded that the pH value had been checked prior to commencing the feed, but did not document the check of the tube length. We saw that whilst feed batch numbers were sometimes recorded in the comments box, this was not consistent for all feeds. The actual volume of feed administered was not documented despite some feeds noted to have ended earlier than prescribed.

Area of good practice

■ Mealtimes were well managed and co-ordinated.
Areas for improvement

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

5. NHS Tayside must ensure that the complex nutritional care standards are followed for patients requiring artificial nutrition via an enteral feeding tube. This includes the care and management of the feeding tube and administration of the feed.

Outcome 8: Pressure area care
Where avoidable, the patient does not acquire a pressure ulcer during their stay in hospital. If they are admitted with a pressure ulcer their care is tailored to their needs.

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

SSKIN bundles

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

84. NHS Tayside have incorporated the SSKIN bundle into the 24 hour care round documentation. We saw that there is a separate row for recording the times of interventions relating to the SSKIN elements.

85. We found the SSKIN bundles were in place for all patients who required them and we found variable completion of these. We saw that:

- One SSKIN chart showed some gaps of up to 7 hours with no reason recorded.
- Mattress type was not always stated, and
- The time of the interventions was not always recorded for the SSKIN chart section of the care round document.

Wound assessment charts
86. Wound assessment charts can allow a clear plan of management to be developed to promote wound healing in the health record of each patient with a pressure ulcer.

87. During our inspection, two patients had a wound assessment chart in place. We saw that one patient with a pressure ulcer had a wound chart completed, however this was not updated to evidence that any review of the wound had taken place. The other wound chart did not state a specific date of review, therefore it was unclear when staff should review the wound.

Specialist pressure relieving equipment

88. In the wards inspected, we saw pressure relieving mattresses and cushions were available and were seen to be in use. Staff knew how to access specialist pressure relieving equipment, if required.

Tissue viability service

89. We were told that there is no onsite tissue viability service at Stracathro Hospital. Staff told us that this can be accessed at Ninewells Hospital and that they would refer patients by telephone.

90. NHS Tayside use an electronic incident reporting system to record pressure ulcers. Staff told us that they report pressure ulcers grade 2 or above which have developed in their clinical area. We were told at the discussion session that a local review would be carried out by the senior charge nurse if a patient developed a grade 3 or 4 pressure ulcer. We highlighted at the discussion session that there is a potential for some pressure damage not to be reported, if they occurred outwith the current reporting guidelines.

Areas for improvement

6. NHS Tayside must ensure that where SSKIN bundles are required, they are put in place and are consistently and accurately completed. The results of the skin inspection must also be documented and evaluated daily in accordance with local policy.

7. NHS Tayside must ensure that wound assessment charts are in place for those patients with a break in skin integrity to support safe and effective care delivery. This must include accurate recording wound dimensions and tissue type and a clear plan of wound management. These must be appropriately and consistently completed and be easily accessible.
### 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.

#### Communication

91. There was good communication between the ward team. There was also good communication between the multidisciplinary teams.

92. We were told that ward safety briefs take place twice a day to communicate patient’s needs and any other relevant information to all staff. In one ward, we were told that a weekly huddle was used to pass on information and update staff on any developments.

93. We saw evidence of patient and family discussions documented on communication sheets. These were on coloured paper to make them easily identifiable for staff.

#### Documentation

94. Patient’s notes were stored securely and were accessible to staff who required them. Medical and nursing folders had section dividers in use which made them easily located. Some charts were kept at the patient bedside.

95. The majority of entries were legible, dated and signed. However, we saw some poorly photocopied documents that were difficult to read. The front page of the core data set booklet was often left blank. The booklet did not always include the patient identifier number. The date, time and signature on assessments was not always completed.

96. During the inspection we saw various examples of documentation in use, this included different versions of core data set document. We were told that the most up to date version of the document should be being used. Senior staff told us that there were plans to review their current documentation and that they are currently testing a new rapid risk assessment document. NHS Tayside aim to have core documentation, with add in documents that are specific to each area. They also acknowledged the need for staff engagement, face to face education and new guidance for completing the documentation when it is introduced. Senior staff acknowledged that there can be poor completion of documentation when patients are transferred.
Area for improvement

8. NHS Tayside must ensure that all documentation is legible, and has patient identifiable details recorded. This should be at a minimum, the patient’s full name and CHI number.
Appendix 1 – Areas of good practice

NHS Tayside

Outcome 6: Food, fluid and nutrition

1 Mealtimes were well managed and co-ordinated (see page 18).
## 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.

<table>
<thead>
<tr>
<th>Outcome 1: Screening and initial assessment</th>
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| **1** NHS Tayside must ensure that all older people who are admitted to hospital are accurately assessed within the national standard recommended timescales for nutritional screening (including MUST and oral health), and pressure ulcer prevention. There must be evidence of reassessment where required. This includes patients who are initially assessed at pre-assessment clinics prior to admission for surgery (see page 13).

This is to comply with Food, Fluid and Nutritional Care Standards (2014) criteria 2.1, 2.2 2.3 & 2.4 and Prevention and Management of Pressure Ulcers Standards (2016) Standard 3. |

<table>
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<tr>
<th>Outcome 2: Person-centred care planning</th>
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| **2** NHS Tayside must ensure that patients have person-centred care plans in place for all identified care needs. These should be regularly evaluated and updated to reflect changes in the patient’s condition or needs. The care plans should also reflect that patients are involved in care and treatment decisions (see page 15).

This is to comply with The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, 2015); Care of Older People in Hospital Standards (2015) criteria 1.1, 1.4, and 11.2a; and Food, Fluid and Nutritional Care Standards (2014) Criterion 2.9a. |
| **3** NHS Tayside should ensure that care rounding documentation is fully and accurately completed to reflect the care delivered and that the |
Implementation of care rounding is supported by adequate individualised care planning and evaluation of the patient’s care (see page 15).

### Outcome 6: Food, fluid and nutrition

1. **NHS Tayside must ensure that food record and fluid balance charts are used and accurately completed for patients who require them and appropriate action is taken in relation to intake or output as required (see page 19).**

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

2. **NHS Tayside must ensure that the complex nutritional care standards are followed for patients requiring artificial nutrition via an enteral feeding tube. This includes the care and management of the feeding tube and administration of the feed (see page 19).**

   This is to comply with the Complex Nutritional Care Standards (2015), Criteria 2.2, 3.1, 3.2, 3.3, and 3.4

### Outcome 8: Pressure area care

3. **NHS Tayside must ensure that where SSKIN bundles are required, they are put in place and are consistently and accurately completed. The results of the skin inspection must also be documented and evaluated daily in accordance with local policy (see page 20).**

   This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers (2009) Section 4; and The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015) sections 8.2, 10.2 and 10.4.

4. **NHS Tayside must ensure that wound assessment charts are in place for those patients with a break in skin integrity to support safe and effective care delivery. This must include accurate recording wound dimensions and tissue type and a clear plan of wound management. These must be appropriately and consistently completed and be easily accessible (see page 20).**

   This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers (2009) Section 4; and The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015) sections 8.2, 10.2 and 10.4.
Outcome 12: Communication

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<td>8</td>
<td>NHS Tayside must ensure that all documentation is legible, and has patient identifiable details recorded. This should be at a minimum, the patient’s full name and CHI number (see page 22).</td>
</tr>
</tbody>
</table>

This is to comply with The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015); and Generic Medical Record Keeping Guidelines (2009)
Appendix 3 – List of national guidance

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

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

Before inspection
We review a range of information, including a report provided by our data measurement and business intelligence team. The report includes data publically available such as NHS National Scotland Services Scotland publications and reporting platforms and Inpatient Experience Survey. We review previous inspection reports and action plans.

During inspection
We arrive at the hospital and inspect a selection of wards and departments.
We use a range of inspection tools to help us assess the standard of care for older people in hospital.
We have discussions with senior staff and/or operational staff, patients and their family or carers.
We give feedback to the hospital senior staff.
We would carry out a further inspection of the hospital if we identify significant concerns.

After inspection
We publish reports for patients and the public based on what we find during inspections. NHS Staff can use our reports to find out what other hospitals or services do well and use this information to help make improvements. Our reports are available on our website at www.healthcareimprovementscotland.org
We require NHS boards to develop and then update an improvement action plan to address the recommendations we make. We check progress against the improvement action plan.