Healthcare Improvement Scotland is committed to equality. We have assessed the inspection function for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
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1  About this report

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

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

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

This report sets out the findings from our unannounced follow-up inspection to Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde from Tuesday 31 July to Wednesday 1 August 2012.

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

The inspection team was made up of two inspectors, with support from a project officer. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. Membership of the inspection team visiting Glasgow Royal Infirmary can be found in Appendix 2.

The report highlights some areas for improvement. All areas for improvement from this inspection can be found in Appendix 1 on page 12. Wherever possible, the areas for improvement are linked to national standards published by Healthcare Improvement Scotland, its predecessors and the Scottish Government. They also take into consideration other national guidance and best practice. We will state that an NHS board must take action when they are not meeting the recognised standard. Where improvements cannot be directly linked to the recognised standard, but where these improvements will lead to better outcomes for patients, we will state that the NHS board should take action. A list of relevant national standards, guidance and best practice can be found in Appendix 3.

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

Glasgow Royal Infirmary is a large teaching hospital in the east of the city. It has 978 inpatient beds and provides a wide range of services including an accident and emergency department and medicine for the elderly.

We carried out an unannounced follow-up inspection to Glasgow Royal Infirmary from Tuesday 31 July to Wednesday 1 August 2012. The inspection was a follow-up to the announced inspection to Glasgow Royal Infirmary in May 2012.

The inspection in May 2012 resulted in four areas of strength, 17 areas for improvement and one area for continuing improvement. After the inspection, as part of the inspection process, NHS Greater Glasgow and Clyde submitted an action plan detailing how improvements would be made. In one area for improvement, about maintaining patient dignity, NHS Greater Glasgow and Clyde set an immediate timescale for the actions it planned to take to bring about improvement. Therefore, the main purpose of this unannounced inspection was to look at the improvement made by these actions.

During the inspection in May 2012, we also identified areas for improvement in treating patients with dementia and cognitive impairment, and preventing and managing pressure ulcers. NHS Greater Glasgow and Clyde identified that these improvements would be made by September 2012. As part of this follow-up inspection, we have commented on the progress NHS Greater Glasgow and Clyde has made towards meeting these timescales. However, we have not identified any areas for improvement in this report where these had already been identified following the inspection in May 2012 and have not yet reached the timescale for improvement outlined in NHS Greater Glasgow and Clyde’s action plan. This report should be read in conjunction with the report and action plan from the inspection in May 2012. These are available on the Healthcare Improvement Scotland website http://www.healthcareimprovementscotland.org/OPAH.aspx.

We inspected the following areas:

- ward 17/31 (stroke)
- ward 18/19 (medicine for the elderly)
- ward 20/21 (medicine for the elderly)
- ward 27 (orthopaedic rehabilitation), and
- ward 30 (medicine for the elderly).

We also visited the following areas to look specifically at screening of cognitive impairment and risk of developing pressure ulcers:

- ward 2 (respiratory medicine)
- ward 3 (diabetes)
- ward 15 (rheumatology)
- ward 50 (medical receiving)
- ward 51 (medical receiving)
- ward 53 (medical receiving)
- ward 61 (orthopaedics)
- ward 64 (general surgery)
- ward 65 (surgical receiving), and
- ward 67 (surgery).

We also visited ward 36 to look at the refurbished environment in an older part of the hospital.

On the inspection, we spoke with staff and carried out patient interviews and used patient questionnaires. We spoke with 10 patients during the inspection. We received completed questionnaires from 20 patients.

As part of the inspection, we reviewed 47 patient health records to make sure the care planned and delivered was as described in the care plans. For this inspection, we reviewed all patient health records for dementia and cognitive impairment. We also reviewed all of them for preventing and managing pressure ulcers. Of the 47 records we looked at, 30 were only reviewed to check that screening had been completed.

This inspection resulted in two further areas for improvement. A full list of these areas for improvement can be found in Appendix 1 on page 12. If an area for improvement had already been made in the previous inspection report, we did not make a new area for improvement in this report.

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

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

We would like to thank NHS Greater Glasgow and Clyde and in particular all staff at the Glasgow Royal Infirmary for their assistance during the inspection.
3 Our findings

Treating older people with compassion, dignity and respect

Patient comments

Through our patient surveys and patient interviews, patients had the opportunity to give us their opinion of the care they received. All patients interviewed told us that they felt they had received good care, attention and treatment.

- ‘Staff [are] very nice and attentive.’
- ‘Everybody made me comfortable while in this hospital.’

Most patients (90%) told us that staff treated them and their belongings with dignity and respect. However, some patients told us of concerns they had.

- ‘The staff are usually very helpful but sometimes there can be very little communication with patients and visitors themselves. Some staff can be a little abrupt which is not very pleasant for the patient.’

Patient and staff interactions

During the inspection, we observed some interactions between staff and patients that demonstrated compassion in the way care was provided. This is how we would expect to see staff interacting with patients.

- We overheard staff attending to a patient behind drawn curtains. Staff helped the patient to wash and encouraged them to do what they could for themselves. Staff also took time to check that the patient had their glasses and a glass of water to hand before leaving the bedside.
- A nurse gently persuaded a patient who was confused and unsteady on their feet to return to their bedside. The nurse chatted to the patient about the view from the window on the ward. The nurse took time to listen to the patient recall memories about places they could see from the window. They then gently suggested they walk back to the bedside.

Patient environment

During our previous inspection to Glasgow Royal Infirmary in May 2012, we identified several areas relating to the patient environment where improvements could be made. In particular, we highlighted the lack of choice and limited availability of bathing facilities on some wards. We also identified two wards in which, due to the way toilet facilities were laid out, patients who required the assistance of two members of staff to go to the toilet had to use commodes at the bedside. An area for improvement was made that NHS Greater Glasgow and Clyde should review the bathing and toilet facilities in Glasgow Royal Infirmary to ensure that patients are able to choose and access the facilities they require to maintain privacy and dignity.

The action plan that NHS Greater Glasgow and Clyde submitted stated that should funds become available, they would be used to increase the availability of ward toilets in the hospital to ensure two members of staff could assist patients as required. In the meantime, patients who require the assistance of two nurses or use wider walking frames would be supported to use the existing facilities. Lead nurses would monitor the situation and the new arrangements would take effect immediately.
During this inspection, we visited a ward where there were issues with the layout of toilets. While no work had started to address the issues, we were told that capital funds had been agreed and that the refurbishment of the toilets was now on a work programme. However, there were no timescales in place for this work. Staff told us that practice on the ward had not changed. Patients needing the assistance of two members of staff still had to use a commode at the bedside at times due to the lack of adequate facilities. Several staff told us they were not aware of any system in place to monitor this.

On two other wards we visited, there was still an issue regarding access to bathing facilities. There are still only two baths available for 32 patients. There was one shower on each ward, but this was an en-suite facility for an isolation room and not available to the whole ward. On one of the wards, we found that for 2 weeks only one bath hoist was working, making it difficult for patients needing help to have a bath. Staff on the ward told us that this made it difficult to offer patients a choice of bathing facilities.

**Patient dignity**

During the inspection, we saw some instances where patient dignity could have been better preserved.

- One patient was confused and was pulling their gown off. The curtain had been pulled around the patient to prevent them from ‘exposing’ themselves. Drawing the curtains meant the patient was isolated for a long time. We asked the nurse in charge to ensure staff found other ways of preserving the patient’s dignity.
- On another ward, a patient was wearing an ill-fitting gown that exposed their back. The patient was clearly sitting on an incontinence pad. They were positioned next to a full-length window in the bay overlooking the corridor. Although this was raised with the nurse in charge, when we revisited the ward on the second day the patient was in a similar condition.

In speaking with patients and staff, we were given conflicting information about what time patients were woken in the morning. Some staff and patients told us that patients were woken early, between 6am and 6.30am, for observations to be carried out. Other staff told us that they only woke patients early when there was a clinical need to do so, for example, if a patient was particularly unwell or needed their observations checked more frequently.

Because of the conflicting information, on the second day of inspection, we returned to the hospital between 6am and 6.30am and visited five wards. On these wards, very few patients were awake and almost everyone was still in bed. Where staff were attending to patients, they described the care they were giving and why it was necessary at that time. Some members of staff told us it had previously been normal practice on two of the wards to wake all patients early to carry out routine checks such as temperature, pulse and blood pressure. However, they told us this practice had stopped 3 or 4 weeks earlier.

**Area for improvement**

1. NHS Greater Glasgow and Clyde should take immediate action to ensure that patients who require the assistance of two members of staff are supported to use existing toilet facilities as stated in its May 2012 action plan.
Dementia and cognitive impairment

As stated in the report summary, these findings should be read and considered along with the report and action plan from the inspection in May 2012.

Screening

The NHS Greater Glasgow and Clyde self-assessment states that all patients over 65 years of age triaged in the accident and emergency department are screened for cognitive impairment. This is in line with the older people in acute care standards. During our previous inspection, we were only able to identify five patients out of the 26 patient health records we reviewed who had been screened on admission. In the action plan submitted following the last inspection, NHS Greater Glasgow and Clyde reported that all older people, admitted to hospital or assessed in accident and emergency, would be screened for cognitive impairment using agreed tools by September 2012.

As part of this inspection, we looked at the progress made towards this timescale. We found improvements had been made and screening, using an agreed tool, had been carried out in 31 of the 47 health records we looked at. However, it was not always possible to determine when the screening had been carried out as the tools were not always dated and timed. We found that it was not always possible to see how the outcome from the cognitive screening had informed further treatment and care planning. While we saw some evidence that referral had been made to an appropriate specialist nurse or doctor, this was not always the case.

Individual care planning

During the previous inspection, there were no personalised care plans for patients with dementia and cognitive impairment in the patient health records we looked at. In its action plan, NHS Greater Glasgow and Clyde stated it would ensure that nursing and medical care plans reflected the additional needs of those patients with a cognitive impairment by September 2012. Of the 47 health records we looked at during this inspection, we looked at 17 in more detail to check progress with meeting this timescale. We found there was still a lack of personalised information in these patient health records.

A lead nurse within Glasgow Royal Infirmary has developed a form for patients who are anxious or like to walk about excessively that has been trialled locally. This contains prompts for staff about the kind of information that they should gather and take into account when planning care. One of the prompts is to work with the patient and family to get to know their likes, dislikes and important events to help staff communicate effectively with the patient. Although we saw an example of this care plan in a patient’s health record, no personal information about likes, dislikes or significant events was recorded. We also observed a patient on one ward who was very agitated. There were no details in the patient’s health record about how staff could manage their agitation.

Adults with incapacity

NHS Greater Glasgow and Clyde has a consent policy on healthcare assessment, care and treatment. The policy outlines what staff should do to gain consent from patients for the treatment they receive. The policy includes a section on how to manage patients who are unable to give consent due to lack of capacity. This would involve an assessment of the individual’s capacity and completing an adult with incapacity form if the person was deemed not to have capacity. During our previous inspection, we found that these forms were inconsistently completed across the hospital.

During this inspection, we saw seven adult with incapacity forms in place in the 17 health records we looked at in detail. There appeared to be an improvement in the completion of
these forms. Discussions with family members or those who held welfare power of attorney were recorded in patient health records. We noted there were still some issues in the way these forms were being used. Adult with incapacity forms were sometimes in place to allow a specific intervention, for example a surgical procedure. However, there was no record of the person’s capacity to consent to other general aspects of care and treatment. In the action plan submitted following our previous inspection, NHS Greater Glasgow and Clyde stated that it will develop an e-learning module on the use of adult with incapacity legislation within acute settings by September 2012.

Preventing and managing pressure ulcers

As stated in the report summary, these findings should be read and considered along with the report and action plan from the inspection in May 2012.

Risk assessment

The best practice statement for preventing and managing pressure ulcers states that patients should be assessed for the risk of developing pressure ulcers within 6 hours of admission. A pressure ulcer occurs when the skin and underlying tissues are damaged because of pressure or friction. This can happen when someone is unwell, undernourished and unable to move very much. In the previous inspection, we found that most of these assessments had been completed within the 6-hour timescale. During this inspection, we found that the assessment had only been completed in 29 of the 47 health records. Seven of the patients who did not have the assessment completed within 6 hours had been admitted to the same ward.

During our previous inspection, we found that the assessment was not always completed correctly. NHS Greater Glasgow and Clyde stated in its action plan that it would monitor completion of the risk assessments to ensure this area for improvement would be met by September 2012. During this inspection, we looked at 17 patient health records in detail to check the progress towards meeting this timescale. We still saw instances where the risk assessment was not completed correctly. One patient had a body mass index (BMI) of 14 which was not recorded on the risk assessment. BMI is a calculation of weight in relation to height and helps to identify where someone is at risk of being undernourished. A BMI of 14 is below the normal range and should be taken into account when calculating the risk of developing a pressure ulcer. As a result, the level of risk was not correctly calculated.

Care plans

During the previous inspection, we also found that it was not clear how the risk assessment score led to preventative care planning. For example, during this inspection, we reviewed the health record of a patient who was scored as at risk of developing a pressure ulcer at admission. The risk assessment was completed for 2 days, after which a break in the patient’s skin was noted. There was no record of any preventative measures taken during this time. After the patient’s skin broke, a repeat risk assessment was not completed for a week and a pressure relieving mattress was not put in place for 5 days. NHS Greater Glasgow and Clyde stated in their previous action plan that by September 2012, it would ensure that care planning was in place and appropriate equipment was used and documented.

Equipment

In our previous inspection report, we highlighted that staff told us that only five wards could access specialist pressure relieving equipment at weekends. Senior management told us at the time that all wards could access specialist equipment. During this inspection, we were told that access to equipment at the weekend was not available for areas classed as ‘non-
acute’. Staff in these areas described times when they have needed to access the equipment at the weekend, but were unable to do so. For example, one area that is classed as non-acute can have patients admitted 1 day after an operation. As a result, they may need to access the equipment at the weekend if the person’s risk factors increase.

**Area for improvement**

2. NHS Greater Glasgow and Clyde must ensure that all patients admitted to Glasgow Royal Infirmary are assessed for the risk of developing pressure ulcers within 6 hours of their admission.
Appendix 1 – Areas for improvement

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

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

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### Dementia and cognitive impairment

None

### Preventing and managing pressure ulcers

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This is to comply with the Best Practice Statement for Prevention and Management of Pressure Ulcers (March 2009) (Section 2: risk assessment).
Appendix 2 – Details of inspection

The inspection to Glasgow Royal Infirmary, NHS Greater Glasgow and Clyde was conducted from Tuesday 31 July to Wednesday 1 August 2012.

The inspection team consisted of the following members:

**Gareth Marr**
Associate Inspector (Lead)

**Katie Wood**
Associate Inspector

Supported by:

**Sara Jones**
Project Officer
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 Prevention and Management of Pressure Ulcers** (NHS Quality Improvement Scotland, March 2009)
- **Clinical Standards for Food, Fluid and Nutritional Care in Hospitals** (NHS Quality Improvement Scotland, September 2003)
- **Clinical Standards for Older People in Acute Care** (Clinical Standards Board for Scotland, October 2002)
- **Dementia: decisions for dignity** (Mental Welfare Commission, March 2011)
- **National Standards for Clinical Governance and Risk Management** (NHS Quality Improvement Scotland, October 2005)
- **Scottish Intercollegiate Guideline Network (SIGN) Guideline 86 – Management of Patients with Dementia** (SIGN, February 2006)
- **SIGN Guideline 111 – Management of Hip Fracture in Older People** (SIGN, June 2009)
- **Standards of Care for Dementia in Scotland** (Scottish Government, June 2011)
Appendix 4 – Inspection process flow chart

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

Before inspection:
- Self-assessment framework finalised and issued
- NHS board undertakes self-assessment exercise and submits outcomes to Healthcare Improvement Scotland
- Healthcare Improvement Scotland reviews self-assessment submission to inform and prepare on-site inspections

During inspection:
- Arrive at hospital
- Inspections of selected wards and departments
- Individual discussions with senior staff or operational staff, or both, and patients
- Group discussions with NHS board and senior hospital staff
- Feedback with NHS board and senior hospital staff
- Further inspection of hospital if areas of significant concern identified

After inspection:
- Report and improvement action plan published
- Follow-up activity to ensure improvement actions are completed
## Appendix 5 – Glossary of abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
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<tr>
<td>HDL</td>
<td>Health Department Letter</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guideline Network</td>
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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** | Elliott House | 8-10 Hillside Crescent | Edinburgh | EH7 5EA

**Telephone** 0131 623 4300

**Email** [hcis.chiefinspector@nhs.net](mailto:hcis.chiefinspector@nhs.net)

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.