Unannounced Inspection Report – care for older people in acute hospitals

Aberdeen Royal Infirmary and Woodend Hospital | NHS Grampian

6–10 October 2014
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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 inspections to Aberdeen Royal Infirmary and Woodend Hospital, NHS Grampian from Monday 6 October to Friday 10 October 2014 as part of the wider, short-life review of quality and safety at Aberdeen Royal Infirmary.

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 five inspectors and one public partner, with support from a project officer. A key part of the role of the public partner is to talk to patients and listen to what is important to them. The team also included a clinical partner who provided clinical advice and support to the team. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. Membership of the inspection team visiting Aberdeen Royal Infirmary and Woodend Hospital can be found in Appendix 2.

The report highlights areas of strength and areas for improvement. All areas for improvement from this inspection can be found in Appendix 1 on page 24. 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

Aberdeen Royal Infirmary serves primarily the Grampian region. It has approximately 900 staffed beds and a complete range of medical and clinical specialties. In November 2012, the new purpose-built Emergency Care Centre opened, bringing together emergency and urgent care facilities into one building. There are 353 inpatient and day beds in the Emergency Care Centre.

Woodend Hospital is a community hospital located in the Woodend area of Aberdeen and is owned and operated by NHS Grampian. The hospital provides elective orthopaedic surgery, rehabilitation and care of the elderly services in conjunction with the other acute and community hospitals in the NHS Grampian area.

We carried out unannounced inspections to Aberdeen Royal Infirmary and Woodend Hospital from Monday 6 October to Friday 10 October 2014.

We inspected the following areas:

Aberdeen Royal Infirmary
- emergency department
- ward 101 (acute admissions)
- ward 102 (geriatric assessment)
- ward 105 (general medicine)
- ward 107 (respiratory)
- ward 110 (general medicine, dermatology, rheumatology)
- ward 204 (stroke)
- ward 205 (neurology)
- ward 209 (urology)
- ward 211 (short stay surgical)
- ward 212 (orthopaedic trauma)
- ward 306 (geriatrics)
- ward 309 (gynaecology/breast), and
- ward 505 (emergency surgery).

Woodend Hospital
- orthopaedic rehabilitation unit
- stroke rehabilitation unit, and
- ward 15 (care of the elderly rehabilitation).

Before the inspection, we reviewed NHS Grampian’s self-assessment and gathered information about Aberdeen Royal Infirmary and Woodend Hospital from other sources. This included Scotland’s Patient Experience Programme, and other data that relate to the care of older people. Based on our review of this information, we focused the inspection on the care of older people with dementia and cognitive impairment, nutritional care and hydration, and preventing and managing pressure ulcers. Ensuring that older people are treated with compassion, dignity and respect is a focus on all our inspections.
On the inspection, we spoke with staff and used additional tools to gather more information. In all wards, we used a formal observation tool. We carried out 15 periods of observation during the inspection. In each instance, members of our team observed interactions between patients and staff in a set area of the ward for 20 minutes.

We also carried out patient interviews and used patient and carer questionnaires. We spoke with 32 patients during the inspection. We received completed questionnaires from 36 patients and 24 family members, carers or friends.

As part of the inspection, we reviewed 58 patient health records to check the care planned and delivered was as described in the care plans. For this inspection, we reviewed 56 patient health records for dementia and cognitive impairment. Out of these 58 patient health records, we also reviewed 55 of them for nutritional care and hydration, and 55 for preventing and managing pressure ulcers.

**Areas of strength**
We noted areas where NHS Grampian was performing well in relation to the care provided to older people in acute hospitals. This included:

- Woodend Hospital had a person-centred approach to patient care, particularly at mealtimes where food was served in a manner that ensured dignity and respect.

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

- The management of patient flow and capacity in Aberdeen Royal Infirmary and Woodend Hospital is not fit for purpose and puts patient safety at risk.
- Senior nurse and medical leadership must regain the confidence of staff by addressing the issues of staffing, staff motivation, and patient flow and capacity.

**What action we expect the NHS board to take after our inspection**
This inspection resulted in one area of strength and 22 areas for improvement. A full list of the areas for improvement can be found in Appendix 1 on page 24.

We expect NHS Grampian 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](http://www.healthcareimprovementscotland.org/OPAH.aspx).

We would like to thank NHS Grampian and in particular all staff at Aberdeen Royal Infirmary and Woodend Hospital for their assistance during the inspection.
3 Our findings

Treating older people with compassion, dignity and respect

Across the wards inspected we saw many warm, positive interactions between staff and patients. However, a number of the interactions we witnessed were brief, basic interactions that focused only on the care being delivered at that time.

We heard no instances of staff speaking loudly, shouting across the ward to each other or of patients’ confidentiality being compromised. However, we did hear inappropriate language to describe patients, such as referring to patients by their bed number or as ‘decants’.

Decanting is the term used by NHS Grampian to describe when a patient is moved from one ward to another for non-medical reasons to create bed capacity in the hospital. This is also known as ‘boarding’. Staff in Aberdeen Royal Infirmary frequently refer to boarded patients as decants. This is not a dignified or respectful way to refer to patients.

Most patients appeared well groomed and comfortable. Many patients wore their own clothes and others wore appropriate nightwear or hospital pyjamas. We found instances where personal items, such as patients’ spectacles, hearing aids, walking aids and water jugs were not easily accessible for patients in some wards inspected.

Patients were looked after in single sex bays in the wards inspected. Designated male and female toilets and shower facilities were available. Positively, we observed that some patients had personal belongings, including family photographs, in their bedrooms.

Patient flow and capacity

Hospital management staff must carefully plan, and respond quickly during busy periods, to create the bed capacity to admit patients and look after them in the most appropriate place. We saw a number of patients put at risk by what appeared to be a systematic failure of Aberdeen Royal Infirmary to safely and effectively manage patient flow and capacity. Some issues illustrating this failure are outlined below.

We saw nursing staff spending considerable time trying to resolve and follow-up problems with patient flow. However, we found senior management and senior clinical staff had little involvement and gave little support to nursing staff in these issues.

It is recognised that at certain times it is necessary to board patients to create capacity for new admissions. However, it is not good practice to board patients who have a cognitive impairment or dementia or to board patients during the night. Patients are regularly boarded to other wards in Aberdeen Royal Infirmary. For example, we saw surgical wards looking after patients with medical conditions.

We were told that when a patient is boarded they remain under the care of the doctors from their original ward. This can lead to delays in medical care for patients, including pain relief, fluids or providing a discharge letter.

Staff told us that patients, including older people, are often boarded during the night. We confirmed this when reading patient documentation during the inspection. For example, one frail, elderly patient was woken at 4.30am to then be moved at 5.30am. We also saw an example of one patient who discharged themselves at 8.00pm as they were not prepared to be boarded to another ward at that time.
In some wards, when beds became available, they were filled by patients boarded from another ward. This prevented the admission of new patients who should have been in those wards. This resulted in even more patients not being looked after in their specialty area.

We were told that the short stay surgical unit (ward 211) should only be open Monday to Friday and closed over the weekend. However, due to issues with patient flow and capacity, the ward has been opened regularly at weekends to take patients boarded from other areas. On the Sunday before our inspection, 10 patients were in the ward and the ward was staffed mainly with staff from the nurse bank.

Elective patients, coming into Aberdeen Royal Infirmary for planned procedures, can wait a long time for a bed. We were told that one area has had to report incidents of patients spending 7–8 hours in a treatment room before a bed becomes available.

Other examples where capacity and flow caused poor outcomes for patients

- We saw a patient in the emergency department around 2.00pm. The patient had been in the department for approximately 6 hours by the time we saw them. They had been identified for admission to ward 110, but the ward had no general medical beds available. Inspectors then visited ward 110 and identified a bed that had been available since lunchtime. Staff were unsure who the bed was for. After we brought it to the attention of staff, the bed was identified as being for the patient in the emergency department. This was a clear example of a breakdown in communication between the bed management team, ward staff and the emergency department. The next day, we were told that because there was not enough staff to escort them, the patient waited until 6.00pm to be taken to the ward. This meant the patient had spent 10 hours in the emergency department on a trolley, observed by inspectors, then a chair. Staff in the emergency department had also moved the patient to a corridor area for some of this time, because patients coming into the department needed cubicles. The next day, inspectors saw the same patient identified as suitable to be boarded, less than 24 hours after arriving on ward 110. This meant the patient would be moved to another ward to make space on the ward they should have been on. We were concerned this patient’s journey was not appropriate, particularly given their wait in the emergency department. We brought this to the attention of senior staff at the time. They agreed and the patient was then not moved from the ward.

- In ward 15 in Woodend Hospital, we saw a patient with dementia who was at significant risk of falls. They had completed their rehabilitation and had been moved to Morningfield House in Woodend Hospital as part of their pathway of care, where they fell and hurt themselves. At 10.45pm on 23 August, a junior doctor saw the patient as a result of the fall. At the time, the junior doctor thought the patient had multiple fractures. The junior doctor intended to discuss the patient with medical staff at Aberdeen Royal Infirmary, and transfer the patient there. Further timely treatment would be given there immediately, in line with the Clinical Standards for Older People in Acute Care. These standards suggest ‘timely treatment’ is to carry out surgery in 24 hours after an incident. At 11.30pm, it was documented that the patient was to be transferred if an X-ray confirmed a fracture. An X-ray was carried out at 2.30am on 24 August, confirming multiple fractures. This was discussed with the on-call orthopaedic registrar at Aberdeen Royal Infirmary. The patient was scheduled for transfer in the morning. Later on 24 August, medical staff again spoke with orthopaedic registrar. Although the registrar told the medical staff no bed was available, they were aware of the need to admit the patient for care of multiple fractures. The fractures included the patient’s hip. Despite further contact from Woodend Hospital’s medical staff, and concerns about the patient’s deterioration as documented in the patient health record, the patient was not transferred to Aberdeen Royal Infirmary until 3.40pm on 26 August. This was 65 hours since the patient was first seen after falling, and they had not been seen by senior orthopaedic medical staff. In the meantime, the patient was looked after in an area for patients fit for discharge and
waiting for care packages. After transfer to Aberdeen Royal Infirmary, it was documented that the patient was in theatre at 6.25pm on 27 August. This was 91 hours since they were first seen after falling. Woodend Hospital has orthopaedic services on site. We escalated this to senior management for further investigation.

**Discharge**

Discharge planning should start from the point of admission to the hospital. With the exception of ward 102, we did not see effective discharge planning documented in patient health records in the wards we inspected. Ward 102 has a discharge co-ordinator and has regular multidisciplinary team meetings.

Ineffective discharge processes are affecting timely discharge. For example, because of the patient transport booking process used, a patient admitted on a Friday afternoon could wait until Tuesday to be discharged if they needed transport arranged.

We were told that wards aim to identify patients for discharge before midday. Aberdeen Royal Infirmary had trialled a discharge lounge to accommodate patients who are ready to go home, but, for example, could be waiting for transport or medication. However, we were told it is now closed because of low staffing levels.

**Staffing**

We recognise the care provided in Aberdeen Royal Infirmary is only possible because of medical and nursing staff’s commitment and dedication in repeatedly covering gaps in the system. We are concerned about the sustainability of safe patient care and the impact on staff wellbeing. We raised this issue with senior management.

Staff told us that wards are continually short staffed. Several wards inspected had less staff on duty than their agreed level. Some wards regularly had two or three staff less than they should have. We were told that it is very difficult to get staff to fill the gaps in staffing levels for each shift when needed. Due to a lack of staff, ward staff were under pressure and being asked to deliver care in extremely difficult circumstances. To maintain a safe service, staff regularly work more than their contracted hours. When on duty, they are unable to leave the ward for breaks. The following are some examples of the staffing levels we found.

- Ward 101 was short of two registered nurses for the day shift and a healthcare support worker for a later shift. The ward staff had escalated this to the hospital bleep holder.
- Emergency department was short of two support staff, and approximately 20% of their staff were on maternity leave.
- Ward 105 was short of two registered nurses in the morning; one was sent to give cover to another area 1–7.15pm.
- Ward 110 was one nursing auxiliary short.
- Staff in surgical wards routinely have to escort patients to theatre. A staff nurse also has to leave the ward to collect patients from theatre and bring them back to the ward safely. Some of the surgical wards are a distance away from theatre. This means there are extended periods of time through the day where surgical wards are left short staffed.

We attended a bed capacity meeting at 3pm where staffing levels were discussed. Conversations in this meeting showed some awareness of the problems faced in patient flow, but solutions were reactive. It was decided that using bank staff, agency staff, ‘floaters’ (staff who can work across all sectors to fill staffing gaps), and staff taken from intensive care unit and high dependency unit would solve the problems. However, we were not assured
that making the decision at that time of day would mean wards would be able to arrange appropriate cover.

We were told ward staff are regularly asked to help cover staff shortages on other wards. We were also told that in some areas, staff are moved based only on the ratio of patients to staff in the ward. This does not take patient care needs on these wards into account.

Leading Better Care recommends that, where possible, senior charge nurses must have protected time for leadership and management duties that ensure safe, effective person-centred care. We saw and heard of examples where senior charge nurses are often unable to have protected management time off the ward because of low staffing levels.

Several staff told us they are confident they give patients good levels of fundamental care. However, they also told us they cannot always deliver the quality of care they would like due to staffing shortages.

We were told NHS Grampian has employed a lot of newly-qualified nursing staff. While this is positive, in some areas there are problems with the ratio of experienced to newly-qualified staff on the wards. Newly-qualified nursing staff have to complete further training after they have qualified so they can perform additional skills such as the administration of intravenous (IV) antibiotics. Where newly-qualified staff have not been trained, more senior staff from other wards have to come deliver care, such as preparing and administering IV antibiotics. Staff stated that the correct skill mix could avoid this happening.

We saw some examples of staff nurses left in charge of wards. While this is acceptable practice, these staff nurses were supported by newly-qualified nurses, rather than other experienced staff nurses. This, combined with a lack of visibility from senior nursing staff, led to a lack of leadership on some wards.

We were told the night shift in one ward try to help day staff by making up a batch of IV drugs for the whole ward. This is not considered to be good practice. On the same ward, we were also told that night shift try to wash two patients. We were told they would wash confused and disorientated patients, who would not realise the time. This practice accommodates the ward’s needs rather than the patient’s, and is not person-centred care.

In one ward, we also found that staff should have started an insulin pump at 6.30am. We were on the ward at 11am and the pump had still not been started. This was raised with senior staff as it can have significant safety implications for the patient.

The Reshaping Care for Older People is a Scottish Government initiative aimed at improving services for older people by shifting care towards anticipatory care and prevention. The Change Fund is part of this project, and gave money to NHS boards to help fund projects that could improve older people’s care. On one ward, we were told a physiotherapy team is a crucial part of the care that is delivered. A year ago, Change Fund money was used to fund this service for the ward when longer term funding for the service was cancelled. Funding for this service is now approved month to month. The physiotherapy service also now works across several other wards rather than just one. Therefore, the service struggles to see patients in a timely, organised manner. This can lead to a delayed discharge for some patients.

Do not attempt cardiopulmonary resuscitation documentation

Do not attempt cardiopulmonary resuscitation (DNACPR) relates to the emergency treatment given when a patient’s heart stops or they stop breathing. Sometimes medical staff will make a decision that they will not attempt to resuscitate a patient. This is because they
are as sure as they can be that resuscitation will not benefit the patient. For example, this could be when a patient has an underlying disease or condition and death is expected. When this decision is made, opportunities should be taken to have honest and open communication to 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 documented in the patient’s health record.

We reviewed DNACPR documentation for 18 patient health records. Of those 18 forms, only two were found to be fully completed. The other 16 DNACPR forms had no date for reviewing the document and seven forms did not document whether the decision had been discussed with the patient or relatives. Therefore, we could not be assured the patient or their relatives were aware of this decision.

We were told of an inappropriate conversation between staff about a patient’s DNACPR status. We raised this with senior staff who assured us that this would be looked into.

Documentation

Not all documentation seen was easy to read because some documents were poor quality photocopies rather than printed copies of assessments. This also made entries written on them difficult to read. Not all entries were legible, dated, timed or signed. Not all documentation was easily accessible.

Staff told us they do not always have time to complete documentation because of pressures from staffing shortages. We saw a lot of documentation not fully completed and we could not then be assured the care given was appropriate. For example, there was evidence of multidisciplinary team working where functional assessments had been completed and indicated a need. Wards actively identified patients with complex discharge needs, and identified patients who would benefit from rehabilitation early in their stay. Although this was evident where referrals had been made for discharge support, it was not evidenced in patient health records.

A system called the Scottish Early Warning Score (SEWS) is in place to alert staff of deterioration in a patient’s medical condition while in hospital. A high score in SEWS should prompt action from nursing and medical staff. They should escalate care to the most appropriate team member for prompt, safe, effective care in the right setting.

SEWS charts are used in both Aberdeen Royal Infirmary and Woodend Hospital. We asked staff about the local escalation process for deteriorating patients and how they determined when, and how often, observations should be carried out. Only one ward could tell us about the escalation process in the hospital.

Staff told us the escalation process used to be part of the SEWS chart. This escalation process would show nursing staff what they should do to assure safety for patients when their SEWS was high enough to prompt action. This escalation process was from all charts in Aberdeen Royal Infirmary. We were told it was removed as a result of staff feedback, as nursing staff wanted more room on the documentation to record observations. We saw no evidence that the escalation process was well known in Aberdeen Royal Infirmary.

We asked medical staff if they knew of the escalation process. They told us the nurses tell them if a patient is unwell. However, we saw examples of patients with SEWS high enough to prompt action but no documentation of escalation to the medical team. We found that processes to keep deteriorating patients safe in Aberdeen Royal Infirmary are weak. Staff are not well informed about the escalation policy and we are concerned that the escalation policy was removed from SEWS charts. The following examples illustrate our concerns.

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• A patient’s SEWS should have prompted action at midday, and was documented in the nursing records. However, the patient was never escalated to medical staff. Repeat observations were not carried out until 8pm; 8 hours after their high SEWS. The patient was then moved at 1.00am to another ward and did not have documented observations until 6.15am despite receiving continuous IV drugs to prevent blood clots. The patient’s SEWS was high enough to prompt action again at 9.25am, and there was no documented evidence of escalation. This patient became acutely unwell.

• We asked staff in ward 212 when they would repeat observations if a patient’s SEWS was high enough to prompt action at 1.50am. Staff told us they would usually wait until the afternoon. The notes reviewed on that ward highlighted an example of observations stating change in the patient’s medical condition at 1.50am. No observations were carried out by 1.30pm the next day. This patient had received morphine and a reduction in oxygen levels. No repeat observations were carried out.

**Bedrail assessments**

Bedrails were seen in use in all wards inspected. Evidence that risk assessments had been carried out to make sure they were used safely was not always found in patient health records. After our previous inspection in April 2013, NHS Grampian introduced a bedrail protocol, which includes the protocol for consent to use bedrails. The protocol also suggests alternatives, such as high low beds, floor mats and sensor alarms.

However, we were told one ward did not have access to high low beds for patients who would climb out of bed and were at high risk of falls.

**Leadership**

The significant issues identified during our visit have led us to believe that the senior nursing and medical leadership is weak, and has led to staff having little confidence in their leadership.

**Patient comments**

Patients had the opportunity to give us their opinion about the care they received through our patient surveys and interviews. Overall, patients were complimentary about the care and assistance they had received from all members of staff. Most patients said they were included in conversations about their treatment and that questions were answered in terms they understood. Patients also stated that staff introduce themselves and are compassionate and considerate. Of the 36 patients who completed our questionnaire:

• 75% stated they had been given clear information about their condition and treatment
• 89% stated the quality of care they received was good, and
• 86% stated that staff explained treatment in a way the patient could understand.

Through our carer and visitor questionnaires, family members, carers and friends had the opportunity to give us their opinion of the hospital. Of the 24 people who completed our carer and visitor questionnaire:

• 92% stated that staff ‘Take the time to get to know the person I am visiting, as a person’
• 92% stated ‘The quality of care the person I am visiting receives is very good’, and
• 88% stated that ‘Staff seemed knowledgeable about the care and treatment of the person I am visiting’.

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We received positive comments from patients through our surveys and interviews.

- ‘Staff on this floor are magnificent, no airs or graces, good attitude, staff approachable’.
- ‘The staff, doctors, nurses, domestics have all been marvellous in attending to me - even young trainee nurses and newly-qualified nurses all displaying enthusiasm and the required desire to be professional. I have lamented in the past the absence of matrons and the management skills they brought to the daily routine - the girls and ladies in 101 and 209 are their own matrons! - caring, skilled and professional - all angels! (and the food's great!)’.
- ‘I was in hospital for three weeks in August for major surgery, and I have now been back for a week. Throughout my time in hospital the care I have received has been quite exceptional’.
- ‘Being spoilt, the attention I get, nothing is a bother’.

We received positive comments from relatives through our surveys and interviews.

- ‘Very good care. Nursing staff very nice and helpful’.
- ‘I have been well informed and felt included in decisions regarding my father’s care in hospital’.
- ‘The staff in this ward are excellent in every way, cannot fault them, for all the pressure they are under they could not be better. My dad gets the best of treatment’.

However, some patients and relatives told us of some concerns and worries they had.

- ‘Short staffed as is always the case. Staff therefore are rushed to the point that I miss asking them to adjust my table, so it is in reach. Very little time to check my fluid top ups. ....Not their fault: Give them more staff, less “managers”’.
- ‘the final touches are missing, I feel at times that staff are rushed and I have to remind them of the little extras, pulling the table closer, pouring a drink’.
- ‘Some staff are either reluctant or too busy to give regular pain relief. My husband sometimes has to wait over an hour after asking. This is usually due to staff shortage’.

Areas for improvement

1. NHS Grampian must ensure clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR).
2. NHS Grampian must ensure all documentation, both nursing and medical, is legible, dated, timed and signed. It should provide details of any assessments and reviews undertaken, and provide clear evidence of the arrangements that have been made for future and ongoing care. It should also include details of information given about care and treatment.
3. NHS Grampian must ensure effective discharge planning begins on, or shortly after admission, and is a continual process.
4. NHS Grampian must ensure that all patients, where clinically appropriate, are treated in accordance with the standards set out in the Clinical Standards for Older People in Acute Care.
5. NHS Grampian should ensure that senior management is aware of the need to support clinical staff, and is able to support them.
6. NHS Grampian should ensure that staffing levels are maintained to the levels determined by its own workforce planning analysis. This should also consider the impact of skill mix and workload.
7. NHS Grampian should ensure bedrail assessments are carried out consistently. This will make sure that no patients are at risk of falling out of bed or that bedrails are not used unnecessarily on patients.

8. NHS Grampian should ensure alternative equipment is available for use where it is identified that bedrails should not be used in line with NHS Grampian protocol. This is to ensure that patients at risk of falls are managed in a way that respects their dignity and rights.

9. NHS Grampian should ensure the management of patient flow in the hospital is fit for purpose, and maintains patient safety, care and dignity.

Dementia and cognitive impairment

Screening and assessment of people with dementia and cognitive impairment

Dementia is a word used to describe a group of symptoms including memory loss, confusion, mood changes and difficulty with day-to-day tasks. Cognitive impairment is when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe.

Following our previous inspection of Aberdeen Royal Infirmary in April 2013, NHS Grampian adopted the 10 point abbreviated mental test (AMT10) for initial cognitive screening of older people. This is used on admission to the acute sector. A screening pathway has also been developed. The cognitive function screening questions have now been included in the nursing admission booklet. This prompts staff to carry out the AMT10 only when concerns are identified. We were told that patients admitted for a planned procedure are not usually cognitively assessed.

We saw that 40 out of 58 patients had been assessed for cognitive impairment using the AMT10. However, it was not always clear how assessment had informed further care. For example, if the assessment tool indicated a possible deficit in cognition, there was not always a follow-up of further cognitive assessment or referral to psychiatric liaison services.

Delirium is a state of acute confusion. There was an inconsistent approach to identifying and managing delirium. Staff understanding and recognition of delirium was varied. Although it may have been the cause of some patients’ confusion, delirium was not considered in several cases. However, we found exemplary delirium care on ward 102, the geriatric assessment unit.

Care planning for people with dementia and cognitive impairment

Following our previous inspection in April 2013 we highlighted personalised care plans for patients with cognitive impairments as an area for improvement. Although care plans were in place, these were not person-centred and did not provide enough detail to help inform care. Staff told us the nursing handover sheet and ward safety briefs were the main ways of communicating information about patient care. Where the patient is moved to another ward, we were not assured the information about the patient’s individual care needs is shared.

NHS Grampian uses the ‘Getting to know me’ booklet. This is completed by the patient, relative or carer for people who have a known diagnosis of dementia. This booklet is used for patients and their carers to highlight personal information to staff such as habits, background, likes and dislikes, and things that are important to them.

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1 Alzheimer’s Research UK: Defeating Dementia – Dementia Information (2014)
2 Cognitive Impairment: A call for action, now! (February 2011)
Use of the ‘Getting to know me’ booklet was inconsistent across the wards inspected. Staff did not always proactively ask relatives to complete the booklet. For example, in one ward we saw two ‘Getting to know me’ booklets left in envelopes for patient’s relatives to complete. However, these were found attached to a clipboard under patient care charts. Where it was completed, it did not always appear to inform care. However, we did see some examples of good practice.

- We saw a patient in ward 306 with a detailed ‘Getting to know me’ document completed by their family. One area highlighted that the patient enjoyed playing cards. We saw a student nurse on the ward playing cards with the patient while we were on the ward. Staff were also familiar with the patient and able to offer reassurance when the patient became distressed.
- In Woodend Hospital, a patient had their favourite items identified, such as their favourite soft toy, and had them in the ward. Staff in this ward knew what and who were important to this patient.

Adults with Incapacity (Scotland) Act 2000

The adults with incapacity form 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. This is someone who is appointed to make decisions on another person’s behalf when they are unable to do so themselves. This can relate to financial and property matters, personal welfare or both. NHS Grampian staff now have to record a ‘yes’ or ‘no’ response to whether a power of attorney or guardianship is identified. This information was well completed in the records viewed. However, where a patient had a power of attorney identified, it was not always clear what decisions this person could make on behalf of the patient. Staff stated they would not routinely ask to see or take a photocopy of the certificate. This could result in decisions being made that the power of attorney or guardian did not have the power to make.

Across the wards inspected, awareness and understanding of the need for capacity assessments was lacking. If a patient is confused, or where their cognitive assessment shows a potential deficit in cognition, a documented assessment of capacity or incapacity form should be completed. We saw several examples where this did not happen.

Where we saw them used, some adults with incapacity forms were generalised and did not reflect the proposed interventions, or that the views of others had been considered. The following are some examples.

- Interventions other than the surgical procedure were not considered in the surgical wards, or were stated as ‘all other hospital care’.
- A patient with cognitive impairment required a feeding tube. The patient had previously pulled out a tube and another was then inserted. There was no adult with incapacity certificate in place to give authority for staff to provide care and treatment. This was brought to the attention of the nurse in charge who then raised it with medical staff.
- Treatment plans to accompany the certificates were signed as having been discussed with medical staff rather than the patient’s relatives or significant others. Therefore, we could not be assured their views, or any previous known wishes of the patient, were obtained.

Environment for patients with dementia and cognitive impairment

People with dementia or a cognitive impairment can benefit from environments that are adapted to limit potential confusion and distress. Most wards were not dementia-friendly environments, particularly in Woodend Hospital where the ward infrastructure was outdated.
However, we saw some adaptations had been made to the environment at Aberdeen Royal Infirmary since our last inspection in April 2013. Pictorial signs had been put up to identify toilets and shower rooms. Large clocks were in most rooms, bays and ward corridors. The majority of wards were brightly lit and uncluttered, and some had been recently refurbished. Contrasting colours to identify different areas in the wards were used in most areas. However, despite signage being used, ‘way finding’ in the hospital can be difficult.

On some wards we inspected in Woodend Hospital, we saw patients had access to lounge and dining areas. The areas appeared comfortable and had a variety of different chairs for patients to use. Having access to these areas allows patients the opportunity to socialise.

Patients undergoing rehabilitation or waiting for services to be put in place to allow discharge may be in hospital for longer periods of time. Therefore, it is important that people are given the opportunity to maintain their cognitive function and to engage in activities that are meaningful to them. We saw activity co-ordinators in the wards we inspected in Aberdeen Royal Infirmary. Activity co-ordinators provide group and individual activities to the patients on wards. In Woodend Hospital, we saw a musician playing the accordion to a group of patients. In ward 204, patients were visited by a Therapet every other weekend. The senior charge nurse on this ward told us the patients enjoy the visits of the Therapet.

### Areas for improvement

10. NHS Grampian must ensure all older people who are being treated in accident and emergency or are admitted to hospital are assessed for cognitive impairment.

11. NHS Grampian must ensure guidelines on the management of delirium are available to all staff who care for acutely unwell people.

12. NHS Grampian must ensure current legislation to protect the rights of patients who lack capacity is fully and appropriately implemented. In order to do so, all staff who have a professional role in the implementation of the legislation must receive training appropriate to their role.

13. NHS Grampian must ensure patients identified as having cognitive impairment have a personalised care plan in place. This should identify the specific needs of the patient and how the staff will meet them.

14. NHS Grampian must ensure systems are in place to record key personal information about people with dementia or other cognitive impairments. This information should be used and be shared with staff involved in the care of the patient.

15. NHS Grampian should ensure that where a welfare power of attorney is identified, the document is checked to establish what powers are held. This will ensure that the decisions being made are within a legal framework.

16. NHS Grampian should carry out an assessment to help them identify how way finding around the wards within Aberdeen Royal Infirmary can be made clearer. In order to do this, the NHS board should involve patient groups and other interested parties.
Nutritional care and hydration

Nutritional screening

NHS Grampian’s self-assessment states that various risk assessments and screenings are carried out when patients are admitted to Aberdeen Royal Infirmary, including the Malnutrition Universal Screening Tool (MUST).

This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. It includes information on a patient’s height and weight, body mass index (BMI), any unplanned weight loss and whether the patient is acutely ill and has not eaten for more than 5 days. BMI is a measure of a person’s weight in relation to their height. Rescreening should take place weekly while the patient remains in hospital.

We saw MUSTs inconsistently completed across the wards inspected. Of the 52 MUSTs we reviewed, 31 had been completed within 24 hours of admission. The majority of patient health records we saw did not state whether figures for heights and weights were measured, reported by the patient or estimated by the nurse. This impacts on the accuracy of the MUST score and medical prescribing and treatment for a patient.

We saw good practice in one ward, where scales were numbered to ensure that the same scales were used each time to ensure consistency of weights.

We found there was nowhere to record if ongoing weekly weights were measured, reported or estimated. Therefore, it would be unclear if a patient is experiencing weight loss and how much, while in hospital.

Accurate patient weights are required from admission, and then regularly while the patient remains in hospital, to support safe and effective treatment. We saw some examples of issues about the accuracy of the weights and BMIs recorded. On one occasion, this led to a patient at risk of under-nutrition not being referred to the dietitian. We visited ward 212 on 7 October. A patient had been admitted 25 days earlier and had no MUST completed. The patient was unable to stand on the ward scales to measure their weight, and hoist weighing scales were broken and waiting for repair. Ward staff did not follow recognised guidance to estimate a MUST score for this patient until an accurate weight could be obtained.

On one ward, staff did not complete MUST on admission. Instead, they relied on older pre-assessment information, such as the patient’s weight. This does not meet the national standard for food, fluid and nutritional care. One patient’s notes we reviewed showed they were on weight-sensitive medication. The prescription for this was based on the patient’s weight from their pre-assessment. It was not clear if the prescribed dose was correct as the patient had not been re-weighed on admission to hospital.

We did not see a section in Aberdeen Royal Infirmary’s MUST document to record:

- the patient’s ‘usual’ weight
- any recent unplanned weight loss, and
- if the patient has been asked about weight loss.

This information is required to complete MUST and therefore we could not be assured that patient MUST scores are accurate in Aberdeen Royal Infirmary.
Nutritional assessments and care plans

We found examples where nutritional assessments detailing any special dietary needs or if a patient needed any help to eat or drink were not always fully or accurately completed. Nutritional assessments are especially important for patients with a known dementia, delirium or communication difficulty. For example, a patient who was a diet-controlled diabetic had ‘normal diet’ recorded on their nutritional assessment. This incorrect information could be passed to ward staff and the incorrect diet or drinks could be given to this patient, which would affect their medical condition. Another patient was ‘nil by mouth’, but this had not been documented on their assessment.

Although all patients had a MUST care plan sheet in their health record, some were blank. This means no information was recorded to guide ward staff on how to meet individual needs. Patients also had a ‘patient care record’ ticked daily for all areas of care, including nutrition. However, this did not always relate to personalised care plans for patients. For example, a patient receiving nutrition through a feeding tube had information from the dietitian about the type, time and rate of feed, but there was no care plan to inform about any other nutritional care or fluid requirements.

Identification of patient needs

All wards had some system in place for identifying individual patient needs for nutritional care and hydration. These included relevant information written above the patient’s bedside and information exchanged between ward staff at shift handover times. Patients who require help with their meals and drinks or who were nil by mouth were also identified in the ward safety briefs. In ward 204, we saw clear individual guidance written by the speech and language therapist on a pink chart above patient’s bedsides. Healthcare assistants told us they would know from the safety briefs and morning handovers who needed help. Red trays and coloured cups are also used to identify patients who need help and promote fluid intake. However, this information was not always recorded in the patient’s care plans or communicated to other ward staff, as the following examples demonstrate.

- In one ward, a patient was at risk of choking on their food and needed support to eat their meal safely. However, their meal tray was put in front of them when they were drowsy and not sitting upright. We had to ask ward staff to help this patient. This issue was raised with the nursing manager and lead nurse.
- In another ward, an inspector had to intervene when a patient was seen at risk of spilling hot tea over themselves. The patient needed help to drink safely, but this was not provided.
- Another patient told us they were occasionally offered food which was not suitable for their diet.
- A dietitian had documented ‘encourage and assist oral intake’ in one patient’s health record. We saw this patient’s meal tray being sat down in front of them and no help or encouragement given from staff. The tray remained untouched and was later removed with nothing having been eaten. We spoke with the nurse looking after the patient. The nurse then tried to find out who had removed the meal tray to establish what had been eaten.
- A blind patient needed help with their meals and drinks. A healthcare support worker giving out meals prompted a staff nurse to stay with the patient and help with their meal, as they seemed unaware of the patient’s needs. We saw this staff nurse then stand over the patient while they helped them eat their lunch.
- In ward 102, a lack of time meant no patient menus had been completed before lunchtime and a mix of meals were sent up from the kitchen. This led to patients who needed help not being identified before the mealtime and an increased risk of patients not receiving the correct therapeutic diet to meet their needs.
Protected mealtimes
We observed several mealtimes during our inspection, including breakfast, lunch and dinner. All wards stated that protected mealtimes were in place. This aims to reduce non-essential interruptions during mealtimes to make sure that eating and drinking are the focus for patients without unnecessary distractions. Adequate numbers of staff should also be available to provide support to patients who need help to eat and drink, in a timely manner. We saw posters on display to explain protected mealtimes and to indicate when meals would be served.

Some patients we spoke with commented that the food was good and they were offered a choice. One patient who requested something else to eat was offered an additional meal.

In Woodend Hospital, we observed good practice during preparation for mealtimes. Patients were offered a choice of whether to eat in the day room or by their bed. They were also offered napkins, cold drinks and a protective apron for their clothes. Mealtimes were well managed in Woodend Hospital, with each course being served separately to make sure food stayed hot. Ward staff put food on plates, which allowed portion sizes to be adjusted where needed. Several patients were seen using the dining room. Patients who needed help received it in a timely manner.

In the wards inspected in Aberdeen Royal Infirmary, the management of patient mealtimes was inconsistent. Some were well co-ordinated, with meals being served in a timely manner and all patients needing help receiving it. However, in some wards, low staffing levels had an impact on care delivered, as demonstrated in the following examples.

- Many patients were not helped to prepare for their meal. This included patients not sitting in a safe eating position or offered hand wipes before eating.
- In one ward, 20 minutes passed before staff began serving meals from the trolley. We saw patients waiting for help and drinks were served 20 minutes after the meal.
- In another ward, it took 45 minutes to give out all the patients’ breakfasts.
- In several wards, one or two healthcare support workers gave out all the patient meals on their own, including positioning meal trays, opening packets and cutting food. This significantly increased the length of time taken to distribute the patient meals.
- Meals were left for patients who were sleeping.
- One patient told us that they had difficulty eating their meal as it was not positioned closely enough to them whilst they were sitting up in bed.
- Staff were not always able to go back and check how patients were managing with their meals because they were too busy.
- In one ward, we heard a member of staff giving out patient meals tell their colleague ‘Don’t answer the buzzers while we’re doing the lunches.’ We heard buzzers go on for a while around this time.
- Breakfast trolleys and toast were prepared for two wards at the same time. This meant that one trolley was left while one ward were served breakfast, resulting in the toast being made 30 minutes before it was served.
- One ward that was short staffed had not collected in used meal trays by 2pm.

Overall, patient mealtimes in Aberdeen Royal Infirmary were not well co-ordinated. Staff nurse involvement in mealtimes, and support offered to patients, were also lacking. We observed one patient being interrupted by a member of the pharmacy team while they ate their meal. However, we did not observe any other interruptions to patients during protected mealtimes.
During our observations, patients were not always given a choice of fresh drink with their meal. Ward staff told us they had access to snacks for patients, including sandwiches, yoghurts and build-up soups, if needed. However, there was an inconsistent approach to what was offered to patients in the evening. Most wards provided a hot drink and biscuits or toast in some areas if requested. However, we were told that if staff were busy they could not provide this. One patient told us they had not been offered a hot drink or snack in the evening. They felt it was a long time to wait between dinner and breakfast time without anything to eat or drink.

**Food and fluid charts**

Food charts and fluid balance charts are used to record how much patients are eating and drinking when this is necessary. Appropriate action should be taken when a patient’s intake or output is not satisfactory. Many fluid charts were well completed, with the previous day’s balance being clearly recorded in red. However, not all fluid charts were fully or accurately completed with running totals, final totals and balances being documented. Charts were also not completed in a timely manner, as needed for effective record-keeping, as in the following examples.

- One patient needed hourly fluid intake monitoring, but this had not been recorded on the fluid chart.
- A patient was noted as dehydrated on admission in their health record. The fluid chart for the previous day for this patient was blank until 1.50pm, indicating no fluids had been taken until that time. The patient was also assessed as being at high risk of malnutrition on MUST. This patient’s food chart had not been completed after breakfast time and the meal trays had since been removed. Therefore, it was unknown what this patient had eaten.
- Another patient’s fluid chart only had 280ml of fluid intake and 300ml of urine output recorded for the previous day. There was nothing documented about the action taken as a result of this low intake and output by nursing staff looking after them.

**Complex nutritional care**

We spoke with the senior charge nurse in ward 204, the stroke ward, about how patients who have had a stroke are given nutritional care. We were told the following.

- Staff nurses in this ward meet core education and training competencies and are trained to assess patients’ swallowing.
- Staff nurses are also trained to pass artificial feeding tubes to administer artificial nutritional support to patients if needed.
- Dietitians assess patients and record the recommended artificial feeding plan.
- Speech and language therapists also assess and recommend safe food and fluids for patients.

We saw all care documented in patient health records on this ward. The senior charge nurse attends a weekly complex nutrition group which provides the opportunity to discuss patients with complex nutritional care needs.

**Areas of strength**

- Meal times in Woodend Hospital demonstrated a person-centred approach to mealtimes. Patients are given the option of eating in a dining room and meals served as separate courses ensuring that each course is warm.
Areas for improvement

17. NHS Grampian must ensure all patients have their height and weight recorded, and are accurately assessed for the risk of under nutrition, within 24 hours of admission to hospital and on an ongoing basis.

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

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

20. NHS Grampian should ensure mealtimes are managed in a manner that ensure that patients are prepared for meals and get assistance in a timely manner.

Preventing and managing pressure ulcers

Assessment

National guidance states that a pressure ulcer risk assessment should be completed within 6 hours of admission. NHS Grampian uses an adapted Waterlow risk assessment tool in ward areas to assess a patient’s risk of developing a pressure ulcer. Patients admitted to the emergency department are assessed using the preliminary pressure ulcer risk assessment (PPURA). The PPURA is included in the patient’s admission documentation.

We saw Waterlow assessments inconsistently completed across the wards inspected. We saw 19 out of 48 had been fully completed within 6 hours of admission. However, eight Waterlow assessments did not note the time they had been filled in on the day of admission. Therefore, we could not be assured it had been carried out within the 6-hour standard.

It was not always clear how the Waterlow score had been calculated as the full assessment was not documented in the patient health record. We were told that in some areas, staff use a laminated copy of the full assessment to obtain the score. Only the total score would then be recorded in the notes. This makes it difficult for staff to identify where changes in condition have been considered in the overall score.

Some of the information contained in the MUST score is also needed for a patient’s Waterlow score. This information was not always accurately recorded, as some patient’s MUST scores were estimated in their Waterlow assessment before their MUST was completed. Other examples of inaccurately completed Waterlow assessments included the following.

- One patient’s age range was recorded differently on three separate occasions. This did change the overall score, but did not impact on the level of risk.
- Another patient’s score did not reflect that they had diabetes. This changed the overall risk from ‘no risk’ to ‘at risk’.

NHS Grampian’s self-assessment states that reassessment should be done daily for all patients. Although the majority of patients had this done, we did see some examples where it was not. For example, one patient whose heels were red had a reassessment carried out four times in 26 days. We saw no evidence to state what interventions had been put in place.

Healthcare Improvement Scotland Unannounced Inspection Report (Aberdeen Royal Infirmary and Woodend Hospital, NHS Grampian): 6–10 October 2014
Care planning
Where a risk was identified, we did not find detailed care plans to inform staff what interventions should be in place to reduce the risk of developing pressure ulcers. Wound management charts were not always seen to be either in place or updated regularly. Therefore, we could not be assured wounds were being appropriately managed. For example, one patient was at very high risk of developing a pressure ulcer. Nursing staff could not assure us the mattress the patient was on was appropriate for the patient’s risk. Documentation to assure us that the patient’s position was being changed appropriately to reduce the risk of skin damage was not in place.

Active care rounding
A skin care bundle, SSKIN (skin, surface, keep moving, incontinence, nutrition), is used across the hospital. This prompts staff to check patients’ skin more regularly and reduce variation in care practice.

We saw the active care checklist in use in the hospital included an adapted SSKIN bundle. Where the adapted SSKIN bundle was used, it was not always clear what interventions were in place. For example, it did not always identify the pressure relieving equipment used or how often the patient should be repositioned. We also saw active care checklists were not always accurately completed. They did not always show how often the patient should be seen. Where this was shown, we saw the active care checklist was not always completed to reflect the patient being seen in the identified time. For example, on one ward a patient’s active care checklist had only been completed three times in 24 days. We could not be assured that the level of care the patient needed was being delivered. We did not observe any patients we thought were not receiving appropriate care. However, we could not be assured this was consistently the case, as the appropriate paperwork was not well completed.

Pressure relieving equipment
Equipment, such as therapeutic air mattresses which help staff to manage and prevent pressure ulcers, was available for patients when needed, and seen to be in use. Pressure relieving cushions are also available and in use. Staff stated they could easily access equipment on the wards, or could phone other wards for equipment if needed.

Areas for improvement

21. NHS Grampian must ensure patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks.

22. NHS Grampian must ensure care planning documentation is improved to provide a clear record of the care required and given to a patient and to show evaluation of that care. This documentation should also demonstrate person-centred and personalised care to meet the needs of individual patients dependent on each patient’s level of risk of developing a pressure ulcer.
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.

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<thead>
<tr>
<th>Treating older people with compassion, dignity and respect</th>
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<tr>
<td><strong>NHS Grampian:</strong></td>
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<tr>
<td><strong>1</strong> must ensure clinical staff consistently comply with the national policy on do not attempt cardiopulmonary resuscitation (DNACPR) (see page 13).</td>
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<tr>
<td>This is to comply with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy – Decision Making and Communication (Scottish Government, May 2010) and SGHD/CMO(2014)17.</td>
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<td><strong>2</strong> must ensure all documentation, both nursing and medical, is legible, dated, timed and signed. It should provide details of any assessments and reviews undertaken, and provide clear evidence of the arrangements that have been made for future and ongoing care. It should also include details of information given about care and treatment (see page 13).</td>
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<td>This is to comply with Nursing &amp; Midwifery Council, Record keeping: Guidance for nurses and midwives (2009) and the Generic Standards of Record keeping Royal College of Physicians 2009.</td>
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<td><strong>3</strong> must ensure effective discharge planning begins on, or shortly after admission, and is a continual process (see page 13).</td>
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<td>This is to comply with Clinical Standards for Older People in Acute Care Standard 5c.</td>
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<td><strong>4</strong> must ensure that all patients, where clinically appropriate, are treated in accordance with the standards set out in the Clinical Standards for Older People in Acute Care (see page 13).</td>
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<td><strong>5</strong> should ensure that senior management is aware of the need to support clinical staff, and is able to support them (see page 13).</td>
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<td><strong>6</strong> should ensure that staffing levels are maintained to the levels determined by its own workforce planning analysis. This should also consider the impact of skill mix and workload (see page 13).</td>
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<td><strong>7</strong> should ensure bedrail assessments are carried out consistently. This will make sure that no patients are at risk of falling out of bed or that bedrails are not used unnecessarily on patients (see page 14).</td>
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8. should ensure alternative equipment is available for use where it is identified that bedrails should not be used in line with NHS Grampian protocol. This is to ensure that patients at risk of falls are managed in a way that respects their dignity and rights (see page 14).

9. should ensure the management of patient flow in the hospital is fit for purpose, and maintains patient safety, care and dignity (See page 14).

**Dementia and cognitive impairment**

**NHS Grampian:**

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### Nutritional care and hydration

**NHS Grampian:**

17 must ensure all patients have their height and weight recorded, and are accurately assessed for the risk of under nutrition, within 24 hours of admission to hospital and on an ongoing basis (see page 21).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.

18 must ensure personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any help the patient needs to eat their meals, where appropriate. The care plans must provide sufficient detail to guide staff on how to help those patients (see page 21).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.7.

19 must ensure patients’ intake of food and fluid is accurately recorded, monitored and that necessary action is taken if a patient’s intake is inadequate (see page 21).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.6.

20 should ensure mealtimes are managed in a manner that ensure that patients are prepared for meals and get assistance in a timely manner (see page 21).

### Preventing and managing pressure ulcers

**NHS Grampian:**

21 must ensure patients are assessed for the risk of developing pressure ulcers within 6 hours of admission to hospital, and are regularly reassessed to take account of any developing risks (see page 22).

This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, section 2.

22 must ensure care planning documentation is improved to provide a clear record of the care required and given to a patient and to show evaluation of that care. This documentation should also demonstrate person-centred and personalised care to meet the needs of individual patients dependent on each patient’s level of risk of developing a pressure ulcer (see page 22).

This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, section 1.
Appendix 2 – Details of inspection

The inspection to Aberdeen Royal Infirmary and Woodend Hospital, NHS Grampian was conducted from Monday 6 October to Friday 10 October 2014.

The inspection team consisted of the following members:

**Ian Smith**
Senior Inspector

**Claire Blackwood**
Inspector

**Kenneth Crosbie**
Inspector

**Gareth Marr**
Inspector

**Irene Robertson**
Inspector

**Karen Goudie**
Clinical Advisor, (NHS board representative from Healthcare Improvement Scotland)

**Penny Leggat**
Public Partner

Supported by:

**Ross McFarlane**
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.
### Appendix 5 – Glossary of abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMT10</td>
<td>a 10 question abbreviated mental test</td>
</tr>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
</tr>
<tr>
<td>DNACPR</td>
<td>do not attempt cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>HDL</td>
<td>Health Department Letter</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
</tr>
<tr>
<td>PPURA</td>
<td>preliminary pressure ulcer risk assessment</td>
</tr>
<tr>
<td>SEWS</td>
<td>Scottish Early Warning Score</td>
</tr>
<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
</tr>
<tr>
<td>SSKIN</td>
<td>skin, surface, keep moving, incontinence, nutrition</td>
</tr>
</tbody>
</table>
How to contact us

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

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

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Email hcis.chiefinspector@nhs.net

www.healthcareimprovementscotland.org

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