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 inspection to Southern General Hospital, NHS Greater Glasgow and Clyde from Tuesday 18 to Thursday 20 February 2014.

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 two public partners, with support from a project officer. The team also included an Improvement Advisor who provided advice on the improvement methodology used within the hospital, particularly on the use of the tool to identify delirium. One inspector led the team and was responsible for guiding them and ensuring the team members agreed about the findings reached. A key part of the role of the public partners is to talk to patients and listen to what is important to them. Membership of the inspection team visiting Southern General 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 16. 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

The Southern General Hospital, Glasgow, is a teaching hospital with approximately 844 beds. General hospital services are provided for the south-west of the city, with some services provided for the whole city and wider region. Services include accident and emergency, general medicine, general surgery, medicine for the elderly (assessment, rehabilitation and day services), orthopaedic surgery and urology.

We carried out an unannounced inspection to Southern General Hospital from Tuesday 18 to Thursday 20 February 2014. This included a late evening inspection to accident and emergency, ward 7 (surge capacity ward), ward 20 (acute medical receiving unit) and ward 21 (general medicine) on Tuesday 18 February 2014.

We inspected the following areas:

- accident and emergency
- ward 2 (orthopaedics - trauma)
- ward 4 (general surgery)
- ward 7 (surge capacity ward)
- ward 20 (acute medical receiving unit)
- ward 21 (general medicine)
- ward 25 (general medicine)
- Langlands Building (medicine for the elderly unit)
  - ward 54 (elderly assessment)
  - ward 56 (stroke/ stroke rehabilitation), and
  - ward 57 (elderly assessment).

Before the inspection, we reviewed NHS Greater Glasgow and Clyde’s self-assessment and the gathered information about Southern General 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 people with dementia and cognitive impairment, nutritional care and hydration and preventing and managing pressure ulcers. Ensuring that older people are treated with 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 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 questionnaires. We spoke with 29 patients and two carers during the inspection. We received completed questionnaires from 35 patients.

As part of the inspection, we reviewed 29 patient health records to check the care planned and delivered was as described in the care plans. For this inspection, we reviewed 28 patient health records for dementia and cognitive impairment. We also received 29 patient health records for nutritional care and hydration, and preventing and managing pressure ulcers.
Areas of strength
We noted areas where NHS Greater Glasgow and Clyde was performing well in relation to the care provided to older people in acute hospitals which included the following:

- The medicine of the elderly unit in the Langlands building. This includes a garden area which can be used by patients with dementia or other cognitive impairment.
- Staff access to, and the availability of, the pressure relieving equipment.

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

- Improve the documentation in the clinical areas to ensure that appropriate care is giving to patients.
- Improve working practices with the social work departments to make discharge planning more effective.
- Comply with do not attempt cardiopulmonary resuscitation (DNACPR) national guidelines.

What action we expect NHS boards to take after our inspection
This inspection resulted in two areas of strength and 16 areas for improvement. A full list of the areas for improvement can be found in Appendix 1 on page 17.

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 Southern General Hospital for their assistance during the inspection.
3 Our findings

Treating older people with compassion, dignity and respect

With the exception of one ward, all wards were mixed sex wards. All patients were in single sex bays or single rooms. Male and female toilet and shower facilities were available. We found that patient toilets in the older parts of the hospital were not always close to patients who had limited mobility. However, commodes were available in these wards.

Personal items, such as patients’ spectacles, walking aids and water jugs were within easy reach of patients in all wards inspected. We saw that the call buttons were placed near to patients to make them more accessible.

We heard and observed patients being addressed in a respectful manner using their preferred name as identified on nursing documentation.

Information displayed above the beds about personal care needs included symbols showing a plate and cutlery which was used to identify where assistance was needed with eating and drinking. There was also written instructions displayed for staff, such as ‘fluid balance chart’ or ‘food chart’.

In some of the wards inspected, we saw a whiteboard at the nurses station which displayed a range of information. Although this included patient names, there was other personal information listed such as diabetic and ‘on controlled drugs’. Whilst this is useful for staff, it does not respect patient privacy and dignity. NHS Greater Glasgow and Clyde should consider what information about patients is displayed for staff where it can be seen by members of the public.

During our inspection, we saw a patient in the Langlands building who required an X-ray. The patient had to be taken to the X-ray department, which is located in a different building despite their being an X-ray department in the Langlands building. This meant that a member of staff had to go with the patient in an internal ambulance to be driven to the X-ray department. However, we were told that internal ambulances cannot always wait for patients, so some patients can wait up to 2 hours to be transferred back to their ward. All X-rays that are required after 2.00pm take place in the main X-ray department. We were told that there is no technical reason why the X-ray could not have been performed in the Langlands building. We are not assured that this process demonstrates good person-centred care. This is a system that is designed to meet the needs of the organisation not the patient.

Patient comments

Through our surveys and interviews, patients had the opportunity to give us their opinion of the care they received. Overall, patients were positive about the care and help they received and told us that in our questionnaires. Of the 25 patients who completed our questionnaire:

- 94% said that they had help with washing, dressing and going to the toilet
- 94% said the quality of care they received was good, and
- 91% said staff treat me and my belongings with respect.

We received the following positive comments:

- ‘I feel that the staff go beyond the call of duty.’
- ‘My stay is pleasant and the nurses were excellent.’
• ‘I can honestly say the treatment and help I get from the nurses and staff is superb.’

However, some patients told us of some concerns and worries they had. One patient told us that: ‘there is a lack of variety in my meals. I can't eat gluten and I felt that the choices for food are poor.’

Patient and staff interactions
We used a formal observation tool in all of the wards inspected to observe interactions between staff and patients. The majority of the interactions we observed were positive with patients been cared for in a dignified manner.

Patient flow and capacity
We were concerned about the patient flow and capacity within the Southern General Hospital. We were told that boarding takes place across the hospital. Boarding is when patients are moved from one ward to another to meet the needs of the service not because of the patient’s clinical needs. NHS Greater Glasgow and Clyde ‘patient flow policy’ states that patients with cognitive impairment are not boarded. However, we found this was not the case. For example, a patient with known dementia and increased confusion had several ward moves. Although some of these moves were due to clinical need, some were documented as being due to capacity issues in the hospital.

Staff told us that when ward 20 is full, patients are admitted directly from accident and emergency to other medical wards. While medical cover continues to be provided from the admissions unit, the ward where the patient is admitted directly to does not always get additional nursing staff. For example, on ward 21 there are two staff nurses on overnight. If they have a direct admission this can lead to one nurse spending considerable periods of time with the new patient if they are particularly unwell. This leaves the other nurse and two clinical support workers looking after the other 25 patients on the ward.

In addition, patients can be transferred between the Victoria Hospital, Western Infirmary and the Southern General Hospital to relieve patient flow and capacity issues. Patients can be transferred at anytime during the day or night. We were told that patients with a cognitive impairment are not moved. However, we saw one patient who had a cognitive impairment was moved from Victoria Hospital during the night.

We noted that 48 patients were listed as delayed discharge. We were told that patients are waiting up to 54 days to be allocated a social worker to allow an assessment of needs to be carried out. This is detrimental to the patients as it can lead to issues with cognitive impairment, increased risk of infection and impact on functional ability. Patients should not be kept in hospital longer than they should be. This has a direct impact on patient flow and capacity in Southern General Hospital as it reduces the availability of beds for other patients to be admitted. We were made aware that discussions are ongoing with NHS Greater Glasgow and Clyde and the social work departments to prevent patients discharge being delayed. However, we were concerned that this is an ongoing issue which directly affects patients.

Discharge planning
During the inspection, we saw an inconsistent approach to discharge planning. Effective discharge planning begins on, or shortly after, admission and is a continual process. We saw that on some wards the estimated date of discharge was displayed on the patients’ health records. However, the discharge planning checklists we saw during the inspection were blank. We discussed this with the discharge co-ordinator and they informed us that further work is being undertaken to improve discharge planning. On some wards, staff discuss
discharge plans at multidisciplinary meetings. If issues are identified with a patient being discharged. These meetings allow staff to resolve more quickly any issues identified with a patient being discharged.

**Do not attempt cardiopulmonary resuscitation documentation**

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.

During the inspection, we reviewed nine DNACPR forms and found six had been completed incorrectly. For example:

- one form did not have a review date on the back of the form, and
- three forms had the DNACPR decision documented in the medical notes of the patient, but this was not demonstrated on the DNACPR certificate.

**Areas for improvement**

1. NHS Greater Glasgow and Clyde should review the need to transfer patients for X-ray if there is an appropriate facility near the patients location.
2. NHS Greater Glasgow and Clyde should consider what prompt information for staff is displayed were it can be seen by members of the public. This will ensure patient privacy and dignity is respected.
3. NHS Greater Glasgow and Clyde must ensure that patients with cognitive impairment are not moved to other areas for non-clinical areas.
4. NHS Greater Glasgow and Clyde must work with the social work department to ensure that patients are not kept in hospital longer than they should be.
5. NHS Greater Glasgow and Clyde must ensure effective discharge planning begins when, or shortly after a patient is admitted to hospital.
6. NHS Greater Glasgow and Clyde must ensure that clinical staff consistently complies with the national policy on DNACPR.

**Dementia and cognitive impairment**

**Screening and assessment of people with dementia and cognitive impairment**

NHS Greater Glasgow and Clyde’s self-assessment states that all patients over 65 years of age are assessed for cognitive impairment using a four question abbreviated mental test (AMT4).

We found that 23 out of 28 patients were assessed for cognitive impairment on admission to hospital using the AMT4. However, the result of this did not always prompt further investigation or assessment.
There was no process identified to screen for delirium. We saw no evidence of patient pathways in use for patients with identified delirium. There was variable recognition and understanding of delirium amongst staff.

**Care planning for people with dementia and cognitive impairment**

NHS Greater Glasgow and Clyde are testing the ‘Getting to know me booklet’. This is completed by the patient, relative or carer in preparation for admission. 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.

There was no evidence of care plans being used to inform and evaluate the care being given on the majority of wards inspected. For example, a patient with dementia and increased confusion was receiving one to one care due to distressed and agitated behaviour. We were told that a ward staff member walked outside with the patient to make sure they were safe and had spoke familiar things and the patient’s family. This information was not recorded on a care plan to inform other staff of effective interventions to manage the person’s distress or demonstrate the care the patient had received.

**Adults with incapacity**

From the patient health records we reviewed, we found that adults with incapacity forms had not been completed correctly. We also found staff had variable understanding of the application of the Adults with Incapacity (Scotland) Act 2000. There was little evidence to demonstrate that the principles of the Act were being followed as proposed interventions were general and did not reflect the actual interventions being carried out. For example, a patient with known dementia and increased confusion was refusing further assessments and was displaying distressed behaviour. The patient healthrecord showed that the patient was prescribed and given medication to manage their agitation. The patient also had a member of staff allocated to them at all times to promote patient safety and to manage their agitation. The Adults with Incapacity certificate only covered the consent for ‘fundamental healthcare procedures’ and had no dates for when the certificate was valid from and to. Fundamental healthcare procedures include all measures to promote or safeguard nutrition, hydration, hygiene, skin care and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene. Fundamental healthcare does not include the use of medication to manage agitation.

We cannot be assured that where a person lacks capacity to consent to treatment that the rights of the individual are being protected and that treatment is being given within a legal framework.

There was little evidence to show that assessment of capacity to consent to treatment had been carried out or that the views of significant others had been obtained. For example, we found the following.

- A patient had a certificate in place for the surgery performed, but no other certificate was completed for subsequent medical problems occurring after surgery.
- A patient identified as having a cognitive impairment through use of the AMT4 and reported increased confusion, had no assessment of capacity to consent to treatment and no certificate in place. It was therefore not identified if this person could consent to treatment and provide assurance that their rights were being protected.
- One certificate had the incorrect dates written on it (20 December 2013 – 19 January 2013). The certificate had also expired.
Psychiatric liaison service for older people

Southern General Hospital has a psychiatric liaison service for older people which provides advice, support and consultation to staff. The team currently consists of one full-time nurse and a consultant psychiatrist who does two half-day sessions each week. The consultant psychiatrist is also available for advice and to see patients on an emergency basis out with these sessions. The team will be changing on 1 May 2014. There will be two nurses and a consultant psychiatrist who will do seven sessions each week. The team will cover each of the hospitals in south Glasgow: the Southern General Hospital and the Victoria Infirmary.

The psychiatric liaison works closely with the community mental health team. If the community mental health team are aware a patient has been admitted to the hospital they will let the psychiatric liaison team know. The team is also able to check with the community mental health team about current treatment plans for people who are admitted to the hospital.

The team will see patients both for one-off assessment and advice and for continuing input while they are in hospital. The team is involved in the training of staff, but this can be difficult given the number of patients the team has to see.

Environment for people with dementia and cognitive impairment

People with dementia or cognitive impairment can benefit from environments that are adapted to limit potential confusion and distress. The wards in the medicine of the elderly unit are painted with calm colours and contrast to help patients with dementia. Handrails in the main corridors and door entrances to bedrooms were of a tone that contrasted to the wall making them more visible to patients. Tone is more important in terms of contrast as the aging eye loses the ability to discriminate between colours. Signage in the wards was large with good contrast, with pictorial signage being used for toilets and shower rooms. Wards 54 and 57 included a day room that has a full-time activities co-ordinator who organises activities for the patients. There was a board on display to show what the activities programme was for the week as well as items for reminiscence such as an old TV, telephone, radio and books. This provides meaningful activity for patients with items prompting conversation.

We saw that the medicine for the elderly unit has a garden area which has been designed to provide a familiar looking place to reduce stress, achieve a sense of wellbeing and promote meaningful activity for people with dementia or other cognitive impairment. The garden is in an enclosed area of the unit and is secure, providing a safe environment for patients. It provides the opportunity for patients to walk around the garden and sit and relax. The drying green (which has been set up to look like the drying greens which were found in lots of the old tenement buildings in the area local to the hospital) and the garden shed (which contains old items including newspaper cuttings) provide the opportunity for patients to reminisce.

We found that the general signage at the front entrance was difficult to understand and as the print was small. This made it difficult to find your way to many of the wards in the hospital. There was also no signage in the lifts to indicate what wards were on what floor.

Although many of the wards in the older parts of the hospital will be moving to the new hospital when it opens, there are things that staff could be doing now to make the wards more suitable for people with dementia. For example, one ward appeared cluttered and noisy at times which could be distressing for a person with dementia or cognitive impairment. Also, the pathway to the toilet was obstructed by equipment such as spare walking frames and blood pressure machines. Staff should make sure that patient walkways are clear from obstruction. This will ensure a clear pathway and reduces the distress and risk to patients with cognitive or visual impairment.

Healthcare Improvement Scotland Unannounced Inspection Report (Southern General Hospital, NHS Greater Glasgow and Clyde): 18-20 February 2014
Area of strength

- The medicine of the elderly department in the Langlands building. This includes a garden area which can be used by patients with dementia or other cognitive impairment.

Areas for improvement

7. NHS Greater Glasgow and Clyde must ensure that all people over the age of 65 who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment. Where screening identifies a possible impairment, further assessment or referral to an appropriate specialist must take place.

8. NHS Greater Glasgow and Clyde must ensure that patients identified as having a cognitive impairment have a personalised care plan in place. This care plan should identify the specific needs of the patient and how staff will meet these needs.

9. NHS Greater Glasgow and Clyde must ensure that current legislation to protect the rights of patients who lack capacity is fully and appropriately implemented within Southern General Hospital. 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.

10. NHS Greater Glasgow and Clyde must ensure that staff record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing documentation. This information should be used and be shared with all staff in direct contact with the patient.

Nutritional care and hydration

Nutritional assessment and personalised care plans

NHS Greater Glasgow and Clyde’s self-assessment states that various risk assessments are carried out when patients are admitted to Southern General Hospital, including the Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission.

Of the 29 patient health records reviewed for nutritional care and hydration, 21 had nutritional screening carried out within 24 hours of admission. There was limited evidence of rescreening being carried out within the hospital. This can result in patients who are at risk of malnutrition not being identified and having appropriate interventions and care put in place. We found:

- one patient had no weight or height recorded or MUST completed since they were admitted to hospital nine days earlier. There was no reason documented as to why this had not been done.
- one patient had their height, weight recorded or MUST completed 11 days after admission, and
- a patient was only screened twice in a 6-week period, despite being identified as at risk of malnutrition.
There was also limited information to guide staff on how to meet any identified needs of patients with nutritional requirements. For example, there was no evidence to indicate:

- if help was needed with eating or drinking
- if religious or cultural considerations should be taken into account, and
- a patient’s eating and drinking likes and dislikes.

**Management and provision of nutrition and hydration**

In general, we found an inconsistent approach to the management of mealtimes in the wards inspected. We observed patients not being prepared or appropriately positioned for eating and drinking before their meal arrived. Patients were not encouraged to wash their hands before their meal and no prompt was given to patients to use hand wipes.

We also observed delays in meals being given to patients. For example, in one ward the trolley of breakfast items including a container of porridge was delivered to the ward 10 minutes before staff acknowledged it was there and started to prepare for serving breakfast. Some patients told us that their meals were cold. However, we did see good practice when a member of the ward staff stood at the meal trolley and checked that each patient received the correct meal to make sure that individual dietary requirements are met.

**Protected mealtimes**

During our inspection, we observed six separate mealtimes, which included 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. We saw posters on display to explain protected mealtimes and to indicate when meals would be served.

However, there was an inconsistent approach to applying protected mealtimes with inspectors observing a number of incidences where mealtimes were interrupted for non-urgent reasons. For example, we saw a member of the domestic team cleaning the ward floor during protected mealtime and a patient being transferred into a ward during a protected mealtime.

**Food and fluid balance charts**

Food and fluid balance charts are used to record how much patients are eating and drinking when there are concerns about their intake. During the inspection, we saw an inconsistent approach to completing food and fluid balance charts.

We found that fluid balance charts were only partially completed as no totals or balances were recorded. The outcomes for each day were not carried forward to inform the next day’s treatment. We identified one patient who had recent renal failure who required accurate and up-to-date fluid balance charts. However, these were not completed and did not give us assurance that the care given was appropriate.

**Menu provision and snacks**

We noted that a varied menu was available which provided a choice of food for patients. Some patients we spoke with were complimentary of the quality of the food and the choices on offer. However, some patients provided us with the following comments about the meals they had received:

- ‘Nothing special.’
• ‘All tastes the same.’
• ‘Sometimes the food is warm.’

Ward staff can order snacks from snack menu or light bites for patients, as well as having main menu options. On some wards, we saw a selection of sandwiches and yoghurts were available for patients out with mealtimes.

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<td>11. NHS Greater Glasgow and Clyde must ensure that patients are accurately assessed for the risk of under nutrition, within 24 hours of admission to hospital.</td>
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<td>12. NHS Greater Glasgow and Clyde must review the way mealtimes are managed on the wards and make sure that all non-essential activity (clinical and non-clinical) is stopped during patient mealtimes.</td>
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<td>13. NHS Great Glasgow and Clyde must ensure that food and fluid charts are completed accurately and the necessary action is taken appropriately.</td>
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<td>14. NHS Greater Glasgow and Clyde must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate.</td>
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**Preventing and managing pressure ulcers**

NHS Greater Glasgow and Clyde uses an adapted Waterlow risk assessment tool to assess a patient’s risk of developing a pressure ulcer. National guidance states that an assessment should be completed within 6 hours of admission. However, we found 21 out of 29 Waterlow risk assessments had not been completed within 6 hours of admission.

We found:

- two patients did not have their Waterlow risk assessment carried out until 13 days after admission
- a patient did not have their Waterlow risk assessment carried out until 11 days after admission
- a patient did not have their Waterlow risk assessment carried out until 6 days after admission, and
- a patient did not have their Waterlow risk assessment carried out until a day after admission.

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. This is included as part of the active care rounding documentation to make sure staff closely monitor patients at risk of developing a pressure ulcer.

We found no evidence of care planning to inform individual needs or the frequency that active care rounding should take place.

From the patient documentation available, there was an inconsistent approach to regular ongoing assessment of patients’ skin. For example, a patient who was unable to eat orally and was on artificial nutrition support, had poor mobility and had developed a grade 3 hospital acquired pressure ulcer. The ‘pressure ulcer record’ section of the Waterlow risk assessment had not been completed. There was no care plan to outline the care or
treatment this patient required. For example, how often the patient’s dressings were being changed. The staff nurse looking after the patient estimated that it should be changed every 2 days. Dressing changes were not always documented on the wound treatment page so it was difficult to establish what dressings were being used and how often they should be changed. The staff nurse did not know if the pressure ulcer had been recorded on the incident management recording system (Datix). There was no evidence of this in the patient’s healthrecord.

Another patient had developed a hospital acquired grade 2 pressure ulcer on their heel and was being nursed on an alternating pressure mattress. In grade 2 pressure ulcers, some of the outer surface of the skin (the epidermis) or the deeper layer of skin (the dermis) is damaged, leading to skin loss. The ulcer looks like an open wound or a blister. We saw no documentation as to why the mattress had been changed to an alternating mattress.

We found no evidence that staff had investigated these hospital acquired pressures ulcers.

As there was no evidence of personalised care planning, we were not assured that the care being delivered was appropriate to the individual needs of the patient.

**Specialist pressure relieving equipment**

Equipment, such as therapeutic air mattresses which help staff to manage and prevent pressure ulcers, was available for patients, when needed. There is an electronic system for obtaining equipment with same day delivery and out-of-hours service and staff are aware of how to access this.

During the inspection, we saw specialist mattresses and cushions were in use by patients who were deemed at risk of pressure ulcer damage.

**Tissue viability service**

We spoke with the tissue viability nurse who told us that there are tissue viability link nurses. However due to pressure of work, the link nurses were finding it difficult to attend meetings and improvement learning events.

The tissue viability service is an NHS Greater Glasgow and Clyde wide service linking acute and community to ensure a seamless service. Referrals are prioritised on need following receipt of an electronic referral. All referrals will have a response within 48 hours either by telephone advice or visit. This service is actively engaging with patients to identify ways to improve the service to benefit the patient experience.

**Areas of strength**

- An electronic referral system is used throughout the hospital for obtaining specialist pressure relieving equipment which is delivered the same day. There is also an out-of-hour’s service which allows access to equipment at all times.

**Areas for improvement**

15. NHS Greater Glasgow and Clyde must ensure that all 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.

16. NHS Greater Glasgow and Clyde must ensure that all patients have a personalised care plan which identifies all of their individual needs in relation to preventing and managing pressure ulcers and clearly demonstrates how those needs are to be met.
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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| 3 | must ensure that patients with cognitive impairment are not moved to other areas for non-clinical areas (see page 9).  

This is to comply with Clinical Standards for Older People in Acute Care, Standard 4c |
| 4 | must work with the social work department to ensure that patients are not kept in hospital longer than they should be (see page 9).  

This is to comply with Clinical Standards for Older People in Acute Care, Standard 5a |
| 5 | must ensure effective discharge planning begins when, or shortly after a patient is admitted to hospital (see page 9).  

This is to comply with Clinical Standards for Older People in Acute Care, Standard 5c |
| 6 | must ensure that clinical staff consistently comply with the national policy on DNACPR (see page 9).  

This is to comply with DNACPR Integrated Adult Policy – Decision Making and Communication (Scottish Government, May 2010). |
### Dementia and cognitive impairment

**NHS Greater Glasgow and Clyde:**

7. must ensure that all people over the age of 65 who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment. Where screening identifies a possible impairment, further assessment or referral to an appropriate specialist must take place (see page 12).

This is to comply with Clinical Standards for Older People in Acute Care, Standard 2

8. must ensure that patients identified as having a cognitive impairment have a personalised care plan in place. This care plan should identify the specific needs of the patient and how staff will meet these needs (see page 12).

This is to comply with Standards of Care for Dementia in Scotland, page 15

9. must ensure that current legislation to protect the rights of patients who lack capacity is fully and appropriately implemented within Southern General Hospital. 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 (see page 12).

This is to comply with Adults with Incapacity (Scotland) Act 2000 Part 5 - Medical treatment and research

10. must ensure that staff record key personal information about people with dementia or other cognitive impairments. Patients and their families should be given clear guidance on the purpose of this information when they are completing documentation. This information should be used and be shared with all staff in direct contact with the patient (see page 12).

This is to comply with Standards of Care for Dementia in Scotland, page 26.

### Nutritional care and hydration

**NHS Greater Glasgow and Clyde:**

11. NHS Greater Glasgow and Clyde must ensure that patients are accurately assessed for the risk of under nutrition, within 24 hours of admission to hospital (see page 14).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.1

12. must review the way mealtimes are managed on the wards and make sure that all non-essential activity (clinical and non-clinical) is stopped during patient mealtimes (see page 14).

This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.7
### Nutritional care and hydration (continued)

<table>
<thead>
<tr>
<th>NHS Greater Glasgow and Clyde:</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 must ensure that food and fluid charts are completed accurately and the necessary action is taken appropriately (see page 14).</td>
</tr>
<tr>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.6</td>
</tr>
<tr>
<td>14 must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate (see page 14).</td>
</tr>
<tr>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 2.7</td>
</tr>
</tbody>
</table>

### Preventing and managing pressure ulcers

<table>
<thead>
<tr>
<th>NHS Greater Glasgow and Clyde:</th>
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<tbody>
<tr>
<td>15 must ensure that all 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 16).</td>
</tr>
<tr>
<td>This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 2</td>
</tr>
<tr>
<td>16 must ensure that all patients have a personalised care plan which identifies all of their individual needs in relation to preventing and managing pressure ulcers and clearly demonstrates how those needs are to be met (see page 16).</td>
</tr>
<tr>
<td>This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 4</td>
</tr>
</tbody>
</table>
Appendix 2 – Details of inspection

The inspection to Southern General Hospital, NHS Greater Glasgow and Clyde was conducted from Tuesday 18 February to Thursday 20 February 2014.

The inspection team consisted of the following members:

**Ian Smith**  
Senior Inspector

**Claire Blackwood**  
Inspector

**Gareth Marr**  
Inspector

**Irene Robertson**  
Inspector

**Kenneth Crosbie**  
Inspector

**Karen Goudie**  
National Clinical Lead - Older People in Acute Care Improvement Programme, Healthcare Improvement Scotland

**Ken Barker**  
Public Partner

**Marguerite Robertson**  
Public Partner

Supported by:

**Nicola Aitken**  
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.

- **Adults with Incapacity (Scotland) Act 2000** Part 5 – Medical treatment and research
- **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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMT4</td>
<td>abbreviated mental test</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>MUST</td>
<td>Malnutrition Universal Screening Tool</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.

**Edinburgh Office** | Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB

**Telephone** 0131 623 4300

**Email** hcis.chiefinspector@nhs.net

[www.healthcareimprovementscotland.org](http://www.healthcareimprovementscotland.org)

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