This report is embargoed until 10.00am on Wednesday 30 January 2013

Announced and Unannounced follow-up Inspection Report – care for older people in acute hospitals

Ninewells Hospital | NHS Tayside

24–26 September 2012 and 21 January 2013
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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 announced inspection to Ninewells Hospital, NHS Tayside from Monday 24 September to Wednesday 26 September 2012 and the unannounced follow-up inspection on Monday 21 January 2013.

This report gives a summary of our inspection findings on page 5. Detailed findings from our announced inspection can be found on page 7 and from the unannounced follow-up inspection on page 21.

The inspection teams for both inspections were made up inspectors and public partners with support from a project officer. One inspector led each 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 teams visiting Ninewells Hospital can be found in Appendix 2.

The report highlights areas of strength, areas for improvement and areas for continuing improvement. All areas for improvement from these inspections can be found in Appendix 1 on page 20. 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

Ninewells Hospital, Dundee, serves the region of Angus, Dundee City, North East Fife, and Perth and Kinross. It contains 826 staffed beds and has a full range of healthcare specialties.

We carried out an announced inspection to Ninewells Hospital from Monday 24 September to Wednesday 26 September 2012. Due to concerns we had about the acute medical assessment unit, we carried out a further unannounced follow-up inspection on Monday 21 January 2013.

During the announced inspection in September 2012, we inspected the following areas:
- acute medical assessment unit (also known as ward 15)
- ward 3 (respiratory)
- ward 5 (medicine for the elderly)
- ward 6 (medicine for the elderly)
- ward 17 (orthopaedics), and
- ward 31 (stroke/general medicine - temporarily moved from ward 4).

We also visited the accident and emergency department.

During the unannounced follow-up inspection in January 2013, we inspected the following areas:
- acute medical assessment unit (wards 14 and 15 combined)

We also visited the accident and emergency department.

Before the announced inspection, we reviewed NHS Tayside’s self-assessment and gathered information about Ninewells 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, and nutritional care and hydration.

On both inspections, we spoke with staff and used additional tools to gather more information. In all wards, we used a formal observation tool. We carried out 17 periods of observation during the inspections. In each instance, members of our team observed interactions between patients and staff in a set area of the ward for approximately 20 minutes.

We also carried out patient interviews and used patient questionnaires. We spoke with 30 patients during the inspections. We received completed questionnaires from 34 patients.

As part of both inspections, we reviewed 40 patient health records to check the care planned and delivered was as described in the care plans. Out of the 40 patient health records, we reviewed 23 patient health records for dementia and cognitive impairment and 24 patient health records for nutritional care and hydration.
Areas of strength
We noted areas where NHS Tayside was performing well when providing care to older people in acute hospitals.

Improvements have been made to the ward environment for people with dementia or a cognitive impairment. People with dementia or a cognitive impairment can benefit from environments that are adapted to limit potential confusion and distress. We saw that colours, shapes, numbers and pictures are being used to help patients distinguish each bay area and help them find their way around the ward. New, larger size clocks are in place, many of which had a sign underneath with the name of the hospital. This also helps to orientate patients. NHS Tayside plans to continue with these improvements.

We saw examples of good multidisciplinary teamworking during our inspection.

Areas for improvement
We found that further improvement is required when providing care to older people in acute hospitals.

During our announced inspection in September 2012, we had concerns about how NHS Tayside provided care to vulnerable older people in the acute medical assessment unit. We were concerned about patients' privacy and dignity being compromised due to the mixed sex facility, the lack of space in the unit and the short curtains. We were also concerned about the busy nature of the unit. We saw patients waiting on trolleys and in wheelchairs in the unit corridor. Patients told us that they waited in the acute medical assessment unit for a long time.

We found that screening for cognitive impairment was not routinely carried out in patients over 65 years when admitted to hospital.

We also found that risk assessments for nutritional care and hydration were not accurately carried out within 24 hours of admission.

We found that mealtimes were not always protected and seemed poorly organised on some wards.

However, as a result of our unannounced follow-up inspection in January 2013, we feel assured that progress is being made to address the issues we identified in the acute medical assessment unit. This gives us assurance that actions are being taken to improve the care provided to patients within this unit.

The number of beds in the unit has increased and the unit is being redesigned to better assess and meet the needs of patients and improve the capacity and patient flow through the unit.

These inspections resulted in two areas of strength, 17 areas for improvement and two areas for continuing improvement. A full list of the areas for improvement can be found in Appendix 1 on page 24.

We expect NHS Tayside 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 Tayside and in particular all staff at Ninewells Hospital for their assistance during the inspections.
3 Our findings from the announced inspection (24–26 September 2012)

Treating older people with compassion, dignity and respect

Of the six wards we inspected, the two medicine for the elderly wards were single sex wards. The other four wards were mixed sex wards. With the exception of the acute medical assessment unit, patients were accommodated in either single sex bays or single rooms. Designated male and female toilets and shower facilities were available. On two wards, patients told us of having to queue for toilets and showers. One patient said that the toilet and shower facilities were a ‘bit worn and needed revamped’. Another patient said that they were ‘very dated and needed a freshen up’.

Most ward areas were well lit, bright and fresh smelling. All the wards inspected had a nurse call system in use. Call handsets were placed near to patients to make them accessible.

We noted that some wards were cluttered with healthcare equipment in the bay areas and ward corridors. This could restrict patients who like to walk in the ward and could increase the risk of patients falling.

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. Of the 31 patients who completed our questionnaire, 87% (27 patients) stated that they had been given clear information about their condition and treatment. 90% (28 patients) said the quality of care they received was good.

• ‘My wife and I have been impressed with the atmosphere in the ward and the care given by the staff. Despite the patients, including my mother, having varying degrees of dementia, they are still treated with dignity and respect. I also appreciate being able to speak to my mother on the ward phone.’
• ‘Having had quite a lot of treatment over the last 4 years I have found this to be of the highest standard, very willingly carried out by all staff concerned.’

Some patients told us of some concerns and worries they had.

• A relative who lived a distance from the hospital told us they would like to have times where the doctors and nurses were made available to speak with them about their relative.
• ‘They [medical staff] don’t seem to tell me very much - they obviously know what they’re doing but are not telling me. I suppose I could ask them but their language and mine are totally different.’
• ‘A TV would be nice in the ward.’

Patient and staff interactions

We observed and listened to interactions between staff and patients. We saw warm and caring interactions with patients from a range of staff including nurses, medical staff, physiotherapists and occupational therapists. We saw many examples where staff were encouraging, supportive and compassionate, and talked to patients in a quiet, gentle and respectful manner. On many occasions, we heard staff introducing themselves to patients and checking whether patients were happy to have any care and treatment carried out at
that time. The following examples of what we saw are how we would expect to see staff and patients interacting.

- A student nurse and a clinical support worker helped a patient who became agitated and disorientated in the toilet. The student nurse was calm, gentle, persuasive and respectful and reassured the patient about where they were while helping them back to their chair by the bed and making sure they were seated safely.
- A confused patient was observed putting their cardigan on their legs. Nursing staff helped this patient in a nice manner, gently reminding the patient where she was, put her socks on to keep her warm, and made sure she had a glass of water. All of this was carried out in an unhurried manner despite the busy environment.
- One patient who was unable to speak was using a notebook to communicate with staff.

However, we saw and heard examples where communication with patients and the use of language could be improved. We heard four examples of staff using undignified language when referring to patients eating.

- A nurse described to us how relatives can stay on the wards during mealtimes to help their family member, ‘if they want to stay to feed.’
- A clinical support worker when describing the coloured tray system to us stated: ‘if they have to be fed.’
- Nurses discussing a patient that will need help at mealtimes: ‘I’ll feed her, I’ll feed my wee love.’
- We heard one patient asked by a nurse: ‘Are you not having anything for breakfast?’ to which another nurse responded: ‘She just throws it up anyway’.

We also noted that a poster describing protected mealtimes on the welcome/information board outside one ward states: ‘If your relative needs assistance in feeding…’. This reinforces the use of undignified language.

We met a patient who had difficulties in communicating. We were able to communicate quickly and effectively with the patient using notepaper and a pen. Staff had not given these to the patient to use. The patient told us of their frustration and isolation. They said that they felt uninformed and that staff did not have time to communicate with them in this way. When we asked the patient if they wanted us to leave some paper and a pen for them to use, the patient told us: ‘There’s no point as they [staff] don’t have time.’

**Patient stimulation**

There is a lack of stimulation and activity for patients at Ninewells Hospital. Patients did not have the option of watching television or listening to the radio either at the bedside or in another area. One ward had temporarily lost its day room due to ongoing refurbishment work. The patients on this ward can be in hospital for a long time. Staff told us that they had not realised the detrimental effect the loss of the day room would have on their patients. Day rooms in use on other wards were often uninviting. They were often used for storing equipment and did not have comfortable chairs for patients to use.

There was an identified rest period on one ward where the lights were dimmed in the afternoon. This did not respect patients’ choices. We saw a patient who used a walking aid trying to find their way around the ward at this time. They were having difficulties negotiating obstacles because of the reduced lighting. There was a potential to increase their risk of falling. Additionally, this reduced lighting was restrictive to those patients who chose not to
rest at this time. Staff activity did not reduce at this time. Therefore, the choice of patients who wished to rest was not respected.

Support for patients and carers
We were given information that NHS Tayside recognises and respects the contribution that carers can make to meet the needs of patients while they are in hospital. It also recognises that carers need to be supported in their caring role. Links have been established between Ninewells Hospital and the Dundee Carer’s Centre. The centre works with family members, partners and friends who are caring for someone to provide practical and emotional support to carers, advocacy, training and information about welfare rights and benefits.

Representatives from the Dundee Carer’s Centre have carried out training and awareness raising sessions in the ward areas with nursing staff, occupational therapists, physiotherapists and social work colleagues. The Dundee Carer’s Centre told us that referral rates to local carer’s organisations have increased from approximately nine referrals a year to approximately 65 referrals a year.

Acute medical assessment unit
This unit accepts general practitioner (GP) referrals directly to the unit as well as patients being admitted from the accident and emergency department. We planned to inspect the acute medical assessment unit on the afternoon of Monday 24 September 2012. We found the unit was very busy. All beds were full and some patients were waiting on trolleys and in wheelchairs in the unit corridor (as described in documentation by NHS Tayside). There was limited space for family members accompanying the patients. A 92-year old relative was unable to sit next to their family member as there was no space for a chair. There were privacy and dignity issues for these patients in the corridor. For example, there were no screens around the patients. Patients told us that their ability to eat and drink was restricted. One patient said that she was told it was unsafe for her to eat on the trolley. The following day, we looked at records which were held in the unit. These showed when people arrived in the unit, their provisional diagnosis, where they had come from, and when they were discharged from the unit or found a bed. These records supported our observations and what patients told us about their experience of the acute medical assessment unit. We were concerned about how NHS Tayside provides care to vulnerable older people in this environment.

As the unit was very busy, we decided to continue this unit’s inspection at a later stage. This allowed staff to prioritise patient assessments and admissions that afternoon.

When we revisited the unit the following day, we saw that staff interacted well with patients and took time to care for them in a calm and unhurried manner. On this occasion, all patients had been allocated a bed and there were no patients waiting in the corridor. We also saw good examples of multidisciplinary teamworking. Staff took opportunities to discuss patient care and treatment with each other and engaged with appropriate healthcare professionals when patients’ needs were identified.

We saw patients being treated with compassion, dignity and respect.

• We saw a nurse checking with a male patient about the timing of an outpatient appointment later that morning. The nurse then telephoned the patient’s wife and checked the most convenient way for her to meet her husband to accompany him to his appointment. The nurse then fed back to the patient the outcome of the conversation with his wife. Both the patient and their relative were kept informed at all stages and this was carried out in a patient and unhurried manner. The nurse then asked the patient’s preference about whether he wanted to be dressed in his own clothes or his pyjamas for the appointment.
However, there were occasions when patients’ privacy and dignity were compromised because of the mixed sex facility, the lack of space in the unit and the short curtains.

- We saw two female patients partially exposed in their hospital gowns.
- We were aware that a patient was using a commode. The curtains were drawn, but as the curtains were too short, they compromised the patient’s privacy. We could see the commode wheels and the patient’s feet and ankles. Because of the lack of space at the bedside, their privacy was further compromised when a nurse used the sink immediately outside the curtain. We heard staff asking indiscreetly about the patient’s care needs.

Patient feedback displayed on the ward said that patients would prefer same sex bays. NHS Tayside’s response displayed on the noticeboard was: ‘Due to the nature of this ward, same sex accommodation will always prove to be difficult. However, ongoing work and improvement continues’. When we spoke with patients about privacy and dignity, they also commented to us that they would prefer same sex bays.

Patients expressed their views about their experience of being in the unit.

- ‘Staff were very helpful. Apologised for the long wait to get a bed. Not their fault - they were run off their feet. All due to cutbacks! Perhaps another ward for admittance would relieve the pressure.’
- Another patient told us that they had: ‘a bit of a wait as there was a bit of a bottleneck, but that I am just glad to be in the hospital.’
- ‘Arrived at 10.45pm and never received a bed till 1.45am, very disappointed with this.’
- ‘The staff were under extreme pressure trying to find sufficient beds for patients. They worked really hard to clear patients but there were long (hours) waits which were uncomfortable and it was the early morning hours before each patient found a bed.’
- ‘It can be difficult to speak to staff at times because in this ward in particular staff (doctors and nurses) are very stretched and very, very busy. There appears to be a need for more healthcare assistants to enable other staff to fulfil their roles. All staff I have been in contact with have been approachable, caring and professional but I can see the resource being under pressure.’

Staff told us that busy periods in the acute medical assessment unit with patients in the corridor were reasonably predictable and a regular occurrence. Records of patients attending the unit confirmed this. Our findings and comments we received from patients highlighted examples of when privacy and dignity of patients was still compromised even when there were no patents waiting in the corridor.

### Area of strength

- We saw examples of good multidisciplinary teamworking during our inspection.
Areas for improvement

1. NHS Tayside should ensure that patients’ privacy and dignity are maintained at all times, and that patients are treated with respect. Staff must always use appropriate language when talking about older people in hospital.

2. NHS Tayside must ensure that patients’ choices in everyday activities are recognised and respected.

3. NHS Tayside must ensure that patients have access to a range of activities and stimuli to help keep them active and maintain their current level of physical and mental functioning.

Area of continuing improvement

a. NHS Tayside should continue to recognise and respect the contribution that carers can make to meet the needs of patients while they are in hospital.

Dementia and cognitive impairment

Screening and assessment of people with dementia and cognitive impairment

NHS Tayside’s self-assessment states that older people are screened for cognitive impairment including delirium and dementia. The national standard indicates that all patients over 65 years of age should be screened for cognitive impairment within 24 hours of admission.

We looked at 19 patient health records for cognitive screening. We found that screening for cognitive impairment was not routinely carried out or recorded in patients who are 65 years and over when admitted to hospital.

NHS Tayside is currently working to develop suitable and appropriate cognitive screening and assessment tools. This is being carried out in conjunction with the Older People’s Collaborative.

Record-keeping and care planning for people with dementia and cognitive impairment

The dementia specialists we spoke with told us that there has been a greater emphasis on dementia care in the hospital. They felt that staff had greater confidence and were seeking advice in caring for people with dementia. They said that nurses in the wards were keen to learn and improve their skills. There are plans to continue to raise staff awareness of dementia and improve care.

The Butterfly Scheme has been introduced in some areas of Ninewells Hospital. This is when discreet butterfly symbols are used to allow staff to identify patients with a known diagnosis of dementia. We saw use of this scheme in some wards. Staff told us they found it useful to highlight patients who may have specific needs.

NHS Tayside has started to use the 'This is Me' document. This provides an opportunity for staff to get to know the patient and their carers in order to provide personalised care and treatment to the patient. This document allows patients and their carers to highlight personal information such as habits, background, likes and dislikes and things that are important to them. It also allows carers to identify how involved they wish to be during the patient’s time in hospital.
We noted that this document was not yet widely used across the hospital. Staff told us that if a patient was admitted to hospital with the document already in place, it helped them understand the patient and their wishes. However, the information was not being put to full use in the patient health records we reviewed. This information could be used as part of a patient-centred care plan to support care management, for example when patients become distressed or agitated.

We found an example of a patient with dementia who was described within their patient health record as having episodes of aggressive and challenging behaviour. The patient health record stated that they tended to display this behaviour if they did not have their hearing aid. This patient did not have their hearing aid in during our inspection of the ward. The hearing aid was on top of the bedside locker waiting for a new battery. The patient also wore glasses which were very dirty and they kept taking them off. The patient asked us to clean their glasses for them. There was no personalised care plan to guide staff to make sure there were regular checks of the patient’s hearing aid and that the patient’s glasses were kept clean.

**Adults with Incapacity (Scotland) Act 2000**

From the patient health records we reviewed, we found that adults with incapacity forms were inconsistently completed throughout the hospital. This form is used to provide consent to treatment for patients who are unable to consent themselves. In one ward, we found that adults with incapacity forms were fully completed. For example, an adult with incapacity form had been completed for a patient 2 days after admission to hospital. This covered the patient’s consent to treatment for a period of 12 months. The patient was diagnosed with dementia and had a detailed treatment plan in place. The documentation clearly outlined that the patient’s partner had welfare power of attorney.

In another ward, a patient health record stated that the patient had a welfare power of attorney, but did not record who this was. Where patients have appointed a welfare power of attorney, staff would require contact details. In the same ward, it was recorded that a patient had the capacity to understand and consent to treatment. However, this differed to the adults with incapacity certificate within the patient’s health record.

During the inspection, we reviewed a patient health record in which a social worker had asked if a patient was mentally fit and had the capacity to make decisions. For patients with fluctuating periods of confusion, staff were uncertain about when Adult with Incapacity (Scotland) Act 2000 legislation should be used.

**Environment for people with dementia and cognitive impairment**

NHS Tayside’s self-assessment states that three senior staff have received training at the Dementia Services Development Centre, University of Stirling, in using the dementia design checklist. People with dementia or a cognitive impairment can benefit from environments that are adapted to limit potential confusion and distress. During the inspection, there was evidence that steps had been taken to improve the environment for people with dementia and cognitive impairment.

On the wards inspected, we noted that colours, shapes and numbers had been used to differentiate the ward bays (see Image 1). Side rooms were also numbered and some had pictures on the doors to help patients find their room more easily. We also noted that clocks in the ward bays were large and set to the correct date and time. The clocks were positioned on two walls of the ward bays and all patients could see them. Some clocks had a sign underneath with the name of the hospital to help orientate patients (see Image 2). Work to replace all the clocks was still in progress. However, many of the new clocks were positioned
too high. Current best practice\(^1\) states that older people are less likely to see something that is above 1.2 metres.

Image 1: colours, shapes and numbers used to distinguish bay areas (ward 17)

Image 2: side room door (ward 3)

Image 3: clock and hospital sign (ward 3)

There were some areas of the environment which could be improved for older people with dementia and cognitive impairment.

\(^1\) Design features to assist patients with dementia in general hospitals and emergency departments, University of Stirling, Dementia Services Development Centre, 2012.
• We found that lighting in some areas of the wards inspected was poor. The lights in the toilets are dim and there is no additional natural light. The lights come on automatically when they detect movement. The timing of the sensors does not allow enough time for patients to use the toilet before the lights go off. This cannot be manually overridden and the sensors can only be triggered by movement. Staff told us that patients with mobility restrictions were finding it difficult to trigger the lights when they switched off. This could put them at risk of falling.

• Ward bays had shiny flooring which reflects the light. This makes the floor appear wet and impacts on the ability of people with a cognitive impairment to move around the ward.

**Psychiatric liaison services for older people**

There is a psychiatric liaison service within Ninewells Hospital specifically for older people. The consultant psychiatrist is available one day each week. They work closely with a specialist nurse group to provide a link between the community mental health teams and the medical staff in the hospital.

Staff had a good awareness of the psychiatric liaison service. Staff told us that the service was easily contactable and provided them with assistance and support when needed.

We were told that the specialist nurse group and practice development nurse aim to spend more time on the wards by the end of 2012 to enhance the care of people with cognitive impairment. Staff told us that the specialist nurses have visited their wards and that they found this experience valuable.

**Patient movement**

NHS Tayside’s self-assessment states that there is a system in place to record and collate patient moves around the hospital. There is no system that monitors the number of ward or bed moves for patients with dementia.

People with dementia or cognitive impairment should not be moved unless this is part of their medical treatment or part of their care pathway. Moving patients can increase their level of confusion and lengthen their stay in hospital. NHS Tayside’s self-assessment states that patients with cognitive impairment can sometimes be moved to another ward to accept an urgent admission. One senior charge nurse told us that patients with a cognitive impairment would not be moved beds or between wards. Our findings did not reflect this.

We found evidence that a patient with dementia had been moved to three different wards, with the last move taking place at 1.50am. The patient was then returned to the first ward after becoming ‘agitated and aggressive’. The patient’s health record did not document a reason for the ward moves and did not document what staff had done to calm the patient. From the patient health record, it appeared that medication was used as a first-line treatment. The consultant told us that they had tried to help the patient in other ways before using medication. This had not been documented. The patient’s health record did not contain a personalised care plan to guide staff on triggers which may lead to periods of distress for the patient, and how to care for the patient during these times.

We were told that a patient’s cognitive impairment was considered before any bed or ward move. A number of patients told us of their distress at being transferred either from the acute medical assessment unit to a ward, or from one ward to another, late at night. From the patient health records we reviewed, none of these documented whether the ward moves were related to patients’ clinical needs.

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Patients also told us about being disturbed with patients moving in and out of the wards through the night.

**Area of strength**

- NHS Tayside has carried out improvements to the ward environment to make it more suitable for people with dementia and cognitive impairment. This includes using colours, shapes, pictures and numbers to help orientate patients.

**Areas for improvement**

4. NHS Tayside must ensure that all older people who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment.

5. NHS Tayside 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.

6. NHS Tayside 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.

7. NHS Tayside must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. When legislation is used, this must be fully documented in the patient health record, including any discussion with the patient or family.

8. NHS Tayside must have a system in place that monitors the number of bed or ward moves patients with dementia are subject to when in hospital.

**Area of continuing improvement**

b. NHS Tayside should continue to develop the psychiatric liaison service for older people, which provides advice and information to staff when required.

**Nutritional care and hydration**

**Nutritional assessment and personalised care plans**

NHS Tayside’s self-assessment states that each patient has a nutritional risk assessment carried out using the Malnutrition Universal Screening Tool (MUST). This tool calculates the risk of malnutrition and should be completed within 24 hours of admission. This includes information on a patient’s height and weight, body mass index (BMI), any unplanned weight loss and whether the patient is acutely ill or has not eaten for more than 5 days. The tool also states that reassessment will take place regularly while the patient remains in hospital. We saw evidence of referrals to dietitians and speech and language therapists and they saw patients as a result of these referrals.

We found a lack of available equipment, such as weighing hoists, to weigh people who could not use the sitting or standing scales. We noted that if patients were not weighed on admission for clinical reasons, the reason was not always documented in the patient health record.
We could also not determine whether patients’ height and weight recorded on the MUST assessment were estimated or were an actual weight and height.

Of the 20 patient health records reviewed for nutritional care and hydration, 15 had a nutritional risk assessment carried out within 24 hours of admission.

Although nutritional risk assessments had been carried out, these were not always completed accurately. For example, some scores were calculated incorrectly. This means that patients were assessed as low risk when they should have been assessed as high risk.

We found limited information in the nutritional assessment or care plans about patients’ nutritional needs, likes and dislikes, special dietary requirements, food allergies or any assistance needed with eating and drinking. For patients who had a ‘This is Me’ completed, the dietary and nutritional information was not used to inform a personalised nutritional care plan.

We noted two wards had carried out their own nutritional audits. The results of these audits displayed on the wards indicated that they had not met their own nutritional assessment targets. This was either because the MUST assessment was not completed within 24 hours of admission or information about patients’ eating and drinking likes and dislikes was not gathered. Since the inspection, NHS Tayside told us that both wards had improvement plans in place.

In a number of wards inspected, we saw that oral hygiene equipment was available for patients who were unable to eat and drink. Mouth care is important for patients’ health and wellbeing. There was a lack of evidence to show that oral care was routinely given, in particular for those patients who were unable to take anything orally.

We saw an example where one patient was not to have food and fluid. We saw evidence that a speech and language therapist had identified that the patient was at a very high risk of choking. The nursing notes stated that the patient was not to have water placed beside them. They also stated that the patient was anxious about being thirsty. We noted that a water jug and glass were on the patient’s bedside locker. We observed that the patient’s mouth was dry and their lips were cracked. Oral hygiene items were next to the patient. This included dirty water and used oral swabs. We observed the patient drinking from the glass of dirty water and intervened. The information about this patient was not included in a personalised care plan to ensure the care given was safe and effective.

**Food and fluid balance charts**

Food and fluid balance charts are used to record how much patients are eating and drinking where there are concerns about their intake. Food record charts were in place. However, it was difficult for staff to determine how much food patients had eaten. For example, the food record chart would state that a ‘patient ate half’. It was unclear whether this was half a sandwich or half a full meal. When asked, staff were not able to tell us what the patient had eaten. Staff could not link the patient menus to the food record chart to provide an idea of how much food, or what, patients had eaten.

We found the use of fluid balance charts was variable. Some charts were not added up to determine patients’ fluid intake in a 24-hour period. Some charts did not have targets set for fluid intake. We did not see staff taking opportunities to actively promote fluid intake, for example when delivering care to patients.
We saw no review or evaluation of patients’ food and fluid intake to make sure that patients were eating and drinking enough. This means that staff cannot be sure that patients are getting the nutritional intake they need.

**Provision and assistance of nutrition and hydration**

We observed three mealtimes on six wards during our inspection. Protected mealtimes have been introduced across the hospital. The idea behind protected mealtimes is to reduce non-essential interruptions during mealtimes to make sure that eating and drinking are the focus for patients without unnecessary distractions. From the mealtimes we observed, we saw that mealtimes were not always protected and were poorly organised on some wards.

On two wards, the food trolley took a long time to get from one end of the ward to the other. The trolley doors were open throughout this time.

We saw a patient served porridge approximately 50 minutes after the breakfast trolley arrived on the ward. The patient’s porridge was replaced as it was cold. The patient was told ‘this porridge should still be warm’. Several minutes later, medical staff interrupted the patient while they were eating their breakfast. We revisited this ward the following day. Staff told us that they had already made changes to improve breakfast time for patients based on what we had told them. This included changing the timing of ward rounds to make sure that patients have protected time to eat their breakfast. We acknowledge that these changes will have a positive impact on the outcomes for patients.

There was not a consistent approach across the hospital to getting patients ready for mealtimes. On one ward, we saw staff helping patients get ready for mealtimes, including positioning of bed tables and patients being given the opportunity to wash their hands. This preparation in anticipation of mealtimes was not seen in any of the other wards.

Using adapted cutlery and equipment, such as plate guards, can help patients maintain independence, preserve dignity and increase confidence. We saw variations in the use of this equipment. On one ward, we saw staff giving a patient an adapted spoon when the patient was observed having difficulties eating their breakfast. In contrast, on another ward, we observed a patient getting occasional help from staff to eat. Staff did not stay with the patient to help them throughout their meal. When staff were not with the patient, they struggled to eat any food with the cutlery provided. The meal tray with soup and custard was at the bedside for over an hour. The food was not kept warm. The patient was then given ice cream which they had difficulty eating with the spoon. Staff did not help the patient and we saw the patient use their fingers to try and eat their ice cream. The patient’s care plan did not provide guidance to staff about what help they needed at mealtimes.

**Menus and provision of snacks**

Menus are completed by patients one day in advance. However, as patients can and are moved from one ward to another, the patients’ menu does not follow them. This means that the patients do not always get the food they had requested.

We were told that picture menus are available. These can be used by patients who have difficulties communicating their choices. During our inspection, we did not see these being used.

If patients changed their mind about their meal choice, they were offered an alternative option from the meal trolley. Outwith mealtimes, we were told that hot meals could not be provided. Patients who miss a meal, either from being off the wards during mealtimes for procedures or were too unwell to eat at mealtimes, could not be provided with a hot meal. This includes patients who require texture-modified or other special diets.
Snacks, such as sandwiches and yoghurts, are available out of hours for patients who have missed a meal or who wish to have a snack outwith mealtimes. However, we noted that most of the snacks available on the snack menu would be unsuitable for patients on specialist diets, such as people with coeliac disease (adverse reactions to gluten).

On one ward, staff were removing patients’ afternoon snacks from their lunchtime meal trays before the trays were given to patients. Patients can choose a snack, such as biscuits or cakes, and may wish to eat them later in the day. The senior charge nurse told us that a generic stock of snacks was kept on the ward which staff would hand out to patients. This meant that patients did not receive the choice of snack they had made from the menu and could not choose when to eat their snack.

On two wards, we noted that the expected mid-morning refreshments were not provided. Staff seemed unaware that this had not happened and we had to bring this to their attention. Patients who need a special diet, such as a texture modified diet, order their food from a special menu. We were told that the therapeutic diet menus have not yet been nutritionally analysed. On one ward, we noted that all the patients on a special diet had not been given the correct diet menu. The diet kitchen, which keeps a record of patients on special diets, changed all the patients’ meals to suit their dietary requirements. Systems within the hospital made sure that patients were not given inappropriate food for their needs. However, as patients were given the wrong menus, they did not get the food choices they were expecting. Patients had not been told why they did not receive what they had ordered.

Patients are offered soup and sandwiches at lunchtime in the acute medical assessment unit. On the day of the inspection, the pre-packaged sandwiches were delivered with the soup. The sandwiches were stored in the hot food compartment of the trolley. This can make them unappetising. When we revisited the unit, staff told us that, based on what we had seen, they had already spoken with catering staff about the delivery of sandwiches to the wards. We acknowledge that the changes will have a positive impact on the outcomes for patients.

Areas for improvement

9. NHS Tayside must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital.

10. NHS Tayside must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance 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.

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

12. NHS Tayside 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.

13. NHS Tayside must ensure that there are no delays in delivering meals to patients and that food is served at the correct temperature.
14. NHS Tayside must ensure that patients requiring specialist diets, such as people with coeliac disease, have access to suitable food outwith the planned menu.

15. NHS Tayside must ensure that all therapeutic diets are analysed for nutritional content by a dietitian.

16. NHS Tayside must ensure that patients are given the opportunity to choose their own food and fluid.

17. NHS Tayside must ensure that patients are provided with equipment and utensils for eating that meet their individual needs.
Our finding from the unannounced follow-up inspection (Monday 21 January 2013)

The announced inspection to Ninewells Hospital in September 2012 identified significant concerns within the acute medical assessment unit. This specifically related to concerns we had about patients’ privacy and dignity being maintained at all times.

During that inspection, we noted issues with:

- the busy nature of the unit resulting in some patients waiting on trolleys and in wheelchairs in the unit corridor
- privacy and dignity issues, such as mixed sex bays and short cubicle curtains not providing adequate privacy, and
- protected mealtimes were not being adhered to and mealtimes were poorly organised.

As a result of these issues we identified, we were concerned about how NHS Tayside provides care to vulnerable older people in this environment. Due to our concerns, we carried out an unannounced follow-up inspection to the unit on Monday 21 January 2013.

Unit environment and redesign

Since the inspection to Ninewells Hospital in September 2012, there has been a significant amount of work carried out to redesign the unit. This redesign work aims to better assess and meet the needs of patients and improve the capacity and patient flow through the unit. Wards 14 and 15 have been combined to increase the number of beds within the unit. One of the existing bay areas has become a temporary designated patient assessment area. This is used to assess patients who may require admission to hospital or who may require an urgent outpatient investigation. A main reception area is still under construction for patients and visitors arriving into the unit. Once works are finalised, this area will also include individual assessment rooms for patients referred for assessment.

Clinical staff told us that they have been involved in the planning for the redesign of the unit. We were told that senior management have been supportive of the clinical staff’s input into the design and operation of the new expanded unit. Staff told us that they feel they have more control over the patient management and patient flow throughout the unit. The redesign and improved patient flow through the unit is enabling more person-centred care to be provided.

During this unannounced inspection, we noted that the unit remains a very busy environment. On this inspection, all patients had been allocated a bed or were being treated by staff in the assessment area and there were no patients waiting in the unit corridor. There were also a number of empty beds available in the unit at that time. All patients we spoke with told us that they had been immediately allocated a bed upon arriving at the unit and there had been no unnecessary or long delays.

We were told that the unit is being temporarily supported by physiotherapists and occupational therapists providing a 7-day service. Staff on the unit were complimentary of the service provided by these staff groups.

We were also told that staffing levels for medical and nursing staff have been reviewed and will increase as a result of the redesign and expansion of the unit.
Treating older people with compassion, dignity and respect
We noted that the unit was calm and well-organised. We saw that patients arriving into the unit were welcomed by staff and directed to either the assessment area or to a bed space as appropriate upon arrival.

All patients appeared well cared for. As before, we saw that staff interacted well with patients and the standard of care was good. We also observed that time was taken to make sure that patients’ relatives were comfortable and kept well informed. We noted that intentional care rounding has been implemented. This is when staff check on individual patients at defined regular intervals to pre-empt any care needs they may have.

We saw no instances when patients’ privacy and dignity was compromised. However, an information notice at the entrance to the unit informs patients and visitors that the acute assessment area (previously ward 15) contains four mixed sex bays. The short stay area (previously ward 14) contains two single sex bays. However, we noted that both bays in the short stay area had a mix of male and female patients, despite both these bays having empty beds available. We also noted that short curtains are still in place throughout the unit.

Screening and patient assessments
We noted that new nursing documentation is now in use. This includes sections for patients and carers to complete if they are able to do so. We found that documentation of care provided to patients was clear and up to date.

Of the six patient health records reviewed during this inspection, we found that screening for cognitive impairment was not carried out or recorded in patients who are 65 years and over when admitted to hospital. One patient who was not screened for cognitive impairment was noted to have acute confusion.

In one patient health record, we noted that a power of attorney had been appointed. This is someone who is appointed to make decisions on someone else’s behalf when they are unable to do so themselves. However, there was no information detailed in the patient health record whether this was a welfare or financial power of attorney.

We noted that a flower symbol is used in the unit, in place of the butterfly symbol, to allow staff to identify patients with a known diagnosis of dementia.

We found no evidence of personalised care plans for patients with a cognitive impairment or dementia.

We also noted an inconsistency in the patient risk assessments carried out for nutrition and pressure ulcers. We found discrepancies between the information gathered at the initial assessment and when the patient was reassessed. We are not clear if these assessments are carried out in the accident and emergency department or in this unit. For example, one patient was assessed on admission to hospital as at low risk of developing a pressure ulcer. However, the reassessment carried out within 24 hours stated that they were at high risk and that the patient had a pressure ulcer.

Of the six patient health records reviewed during this inspection, not all had nutritional risk assessments carried out or completed accurately. In three cases, this was due to a lack of available equipment, such as weighing hoists. We were told that the available equipment is shared between areas. We also found that no personalised care plans were in place, despite one patient being assessed as at high risk of malnutrition on admission to Ninewells Hospital.
Provision and assistance of nutrition and hydration
We observed two mealtimes on the unit during our inspection. We found that both mealtimes were well organised and, although clinical care work took place, patients were not being unnecessarily interrupted while they ate. Staff told us that the timing of the breakfast on the unit has been changed to allow the daily staff briefing to take place beforehand. This helps to make sure that mealtimes are protected and staff are free to distribute meals and provide any help to patients who need assistance to eat and drink.

We noted new food trolleys which had designated hot and cold compartments for storing food appropriately. Staff told us that they were appreciative of the new food trolleys.

We noted that patients also received a mid-morning refreshment.

Feedback from patients
During this inspection, we spoke to seven patients. Overall, feedback from patients was very positive. One patient told us about being admitted to the unit last year and feeling ‘frightened’ about being admitted to the unit again due to ‘so much coming and going on in the unit’. However, feedback from the patient on their current admission was positive. They told us of having a ‘surprisingly pleasant experience’. They felt well looked after and said that staff constantly checked on them. This patient also observed staff caring for a nearby patient who was very unwell with kindness, compassion and respect all through the night.

Other comments we received from patients included:

- ‘Everything’s A1’.
- ‘Nurses are awfully good’.
- ‘Nurses are always attending to me.’
- ‘The amount of work they do is unbelievable’.

One female patient told us that, although happy with her care, she felt she had no information about what was happening to her. This patient had been moved five times, including being moved from the unit to a ward but, as there was no bed available on the ward, the patient was returned to the unit.

As a result of the follow-up inspection, we are assured that much progress has been made to address the issues we identified during the announced inspection in September 2012. This gives us assurance that the actions taken are improving the care provided to patients within this unit.
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

**NHS Tayside:**

1. **should** ensure that patients’ privacy and dignity are maintained at all times, and that patients are treated with respect. Staff must always use appropriate language when talking about older people in hospital (see page 12).

2. **must** ensure that patients’ choices in everyday activities are recognised and respected (see page 12).

   This is to comply with Standards of Care for Dementia in Scotland, page 19.

3. **must** ensure that patients have access to a range of activities and stimuli to help keep them active and maintain their current level of physical and mental functioning (see page 12).

   This is to comply with Standards of Care for Dementia in Scotland, page 25.

### Dementia and cognitive impairment

**NHS Tayside:**

4. **must** ensure that all older people who are being treated in accident and emergency or are admitted to hospital are screened and assessed for cognitive impairment (see page 16).

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

5. **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 16).

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

6. **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 16).

   This is to comply with Standards of Care for Dementia in Scotland, page 26.
Dementia and cognitive impairment (continued)

**NHS Tayside:**

7. must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. When legislation is used, this must be fully documented in the patient health record, including any discussion with the patient or family (see page 16).

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

8. must have a system in place that monitors the number of bed or ward moves patients with dementia are subject to when in hospital (see page 16).

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

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Nutritional care and hydration

**NHS Tayside:**

9. must ensure that all patients have their height and weight recorded, and are accurately assessed for the risk of undernutrition, within 24 hours of admission to hospital (see page 19).

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

10. must ensure that personalised nutritional care plans are developed, implemented and evaluated for each patient, as appropriate. They should include information about any assistance 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 19).

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

11. must ensure that 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 19).

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

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 19).

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

#### NHS Tayside:

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>must ensure that there are no delays in delivering meals to patients and that food is served at the correct temperature (see page 19).</td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.6.</td>
</tr>
<tr>
<td>14</td>
<td>must ensure that patients requiring specialist diets, such as people with coeliac disease, have access to suitable food outwith the planned menu (see page 20).</td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.10.</td>
</tr>
<tr>
<td>15</td>
<td>must ensure that all therapeutic diets are analysed for nutritional content by a dietitian (see page 20).</td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 3.3.</td>
</tr>
<tr>
<td>16</td>
<td>must ensure that patients are given the opportunity to choose their own food and fluid (see page 20).</td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 4.1.</td>
</tr>
<tr>
<td>17</td>
<td>must ensure that patients are provided with equipment and utensils for eating that meet their individual needs (see page 20).</td>
<td>This is to comply with Clinical Standards for Food, Fluid and Nutritional Care in Hospitals, Criterion 4.6.</td>
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Areas for continuing improvement are improvements that the NHS board has already identified and started to address. We acknowledge the work carried out by the NHS board at the time of inspection and encourage progress in these areas.

### Areas for continuing improvement

#### NHS Tayside:

<table>
<thead>
<tr>
<th>Letter</th>
<th>Requirement</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>should continue to recognise and respect the contribution that carers can make to meet the needs of patients while they are in hospital (see page 12).</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>should continue to develop the psychiatric liaison service for older people, which provides advice and information to staff when required (see page 16).</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2 – Details of inspections

The inspection to Ninewells Hospital, NHS Tayside was conducted from **Monday 24 September to Wednesday 26 September 2012.**

The inspection team consisted of the following members:

**Julie Tulloch**  
Associate Inspector (Lead)

**Janet Smith**  
Associate Inspector

**Jane Walker**  
Associate Inspector

**Lynn Burns**  
Public partner

**Penny Leggat**  
Public partner

Supported by:

**Jan Nicolson**  
Project Officer

Observed by:

**Jill Sands**  
Project Officer
The unannounced follow-up inspection to Ninewells Hospital, NHS Tayside was conducted on Monday 21 January 2013.

The inspection team consisted of the following members:

**Ian Smith**  
Regional Inspector

**Jane Walker**  
Associate Inspector

**Lynn Burns**  
Public partner

Supported by:

**Jan Nicolson**  
Project Officer

Observed by:

**Rosemary Lyness**  
Executive Director for Nursing, Midwives and Allied Health Professionals, NHS Lanarkshire

**Robbie Pearson**  
Director of Scrutiny and Assurance, Healthcare Improvement Scotland
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>
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<tbody>
<tr>
<td>BMI</td>
<td>body mass index</td>
</tr>
<tr>
<td>CSBS</td>
<td>Clinical Standards Board for Scotland</td>
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<tr>
<td>HDL</td>
<td>Health Department Letter</td>
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<tr>
<td>MUST</td>
<td>Malnutrition Universal Screening Tool</td>
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<tr>
<td>SIGN</td>
<td>Scottish Intercollegiate Guideline Network</td>
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</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 key components of our organisation.