Review of hospital-based complex clinical care

NHS Lothian

May 2016

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Executive summary

Key messages

- The NHS across Scotland is facing a number of challenges, due to an ageing population, particularly in areas providing care to patients with complex care needs. These pressures are evident in hospital-based complex clinical care (HBCCC) services in NHS Lothian.

- Within the services we visited, we saw evidence of good relationships between staff and a positive culture of openness and willingness to learn from mistakes.

- Since February 2015, NHS Lothian has invested over £1.13 million in nursing staffing, but the use of temporary staff, levels of sickness absence and difficulties in recruiting show pressures on the system. A number of initiatives have been recently introduced to help address these pressures.

- Importantly, there are a number of weaknesses in relation to record keeping, particularly for assessment and care planning. Good record keeping is an important aspect of providing high quality care and the issues we highlight in this report need to be fully addressed.

- Patients and families provided positive feedback but identified some areas for improvement. Many of their comments reflect challenges due to staffing pressures.

- NHS Lothian is putting in place the building blocks to allow its strategic vision for the HBCCC service to be implemented and is working with partners to develop a comprehensive operational plan.

Key recommendations

- **Recommendation 1:** NHS Lothian must carry out further ongoing risk assessments, taking account of the findings in this report, to ensure the levels and skill mix of staff across the hospital-based complex clinical care service meet the needs of its patients.

- **Recommendation 2:** NHS Lothian must standardise its approach to all care plans, assessments and reassessments ensuring that the appropriate documentation is fully and accurately completed.

- **Recommendation 3:** NHS Lothian must ensure there is a consistent application of current clinical management standards and guidance for hospital-based complex clinical care patients.

- **Recommendation 4:** NHS Lothian must ensure that the ward and hospital environments across the hospital-based complex clinical care facilities are appropriate to the needs of the patients, particularly for people with dementia and cognitive impairment.

- **Recommendation 5:** Where appropriate, NHS Lothian must ensure continuing positive engagement with patients, including appropriate cognitive stimulation and activities for patients.

- **Recommendation 6:** NHS Lothian must ensure the ongoing and future development of the hospital-based complex clinical care service takes full account of the financial and workforce implications.

Context

1. Across Scotland, and much of the world, the proportion of older people is growing more rapidly than the rest of the population. This is a major factor contributing to the pressures on health and care services. Changes in the age and health of the population have a significant impact on health and care services, on how much money is needed to fund care, and on the number and skills of staff needed to support people.

2. The population in Edinburgh is projected to continue its recent rapid growth:

   • the population will increase from 482,600 in 2012 to 537,000 in 2022 (11.3% increase over the next 10 years), and

   • the number of people aged 85 and over is projected to more than double by 2037 (110% increase from 10,100 to 21,300).[1]

3. While people are living longer and health is generally improving, the ageing population is having an impact on the number of patients who need hospital-based complex clinical care (HBCCC) and the complexity of their conditions.[2] During our review of the HBCCC service in NHS Lothian (Edinburgh City), medical and nursing staff told us that the profile of the patients they care for has changed dramatically over recent years. Patients are living longer with a wider range of morbidities. As a result, their needs are more complex and they need more medical interventions. Staff recognised that this requires different skills and experience, highlighting the greater focus now on palliative care compared to a previous focus on long-term nursing care.

4. There is widespread recognition that services across Scotland and in other countries need to change to address the challenge of an ageing population. To help services to begin to address these challenges, the Scottish Government introduced the 2020 Vision, with the aim of providing more care for people at home or in a homely setting.[3] This means less reliance on services provided in acute hospital with a vision that in future:

   • we have integrated health and social care services

   • there is a focus on prevention, anticipation and supported self-management

   • where hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm

   • whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions, and

   • there will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

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[1] Edinburgh Health and Social Care Partnership. Draft joint strategic needs assessment. https://consultationhub.edinburgh.gov.uk/hsc/edinburgh-health-and-social-care-partnership-draft

[2] Hospital-based complex clinical care (previously known as long-term care, continuing care or inpatient complex care) is defined as ongoing, non-acute care, delivered as an inpatient, and often over an extended period, either in a hospital, hospice or care home.

[3] Scottish Government. A route map to the 2020 vision for health and social care. May 2013. http://www.gov.scot/Topics/Health/Policy/Quality-Strategy/routemap2020vision

5.   In February 2016, the Scottish Government published a National Clinical Strategy[4] to help NHS boards and their partners implement the 2020 Vision and to look beyond 2020. The strategy proposes that, in future, GPs will focus on care that is more complex and emphasises the importance of using technology to support and improve care.

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[4] Scottish Government. A National Clinical Strategy for Scotland. February 2016. http://www.gov.scot/Publications/2016/02/8699
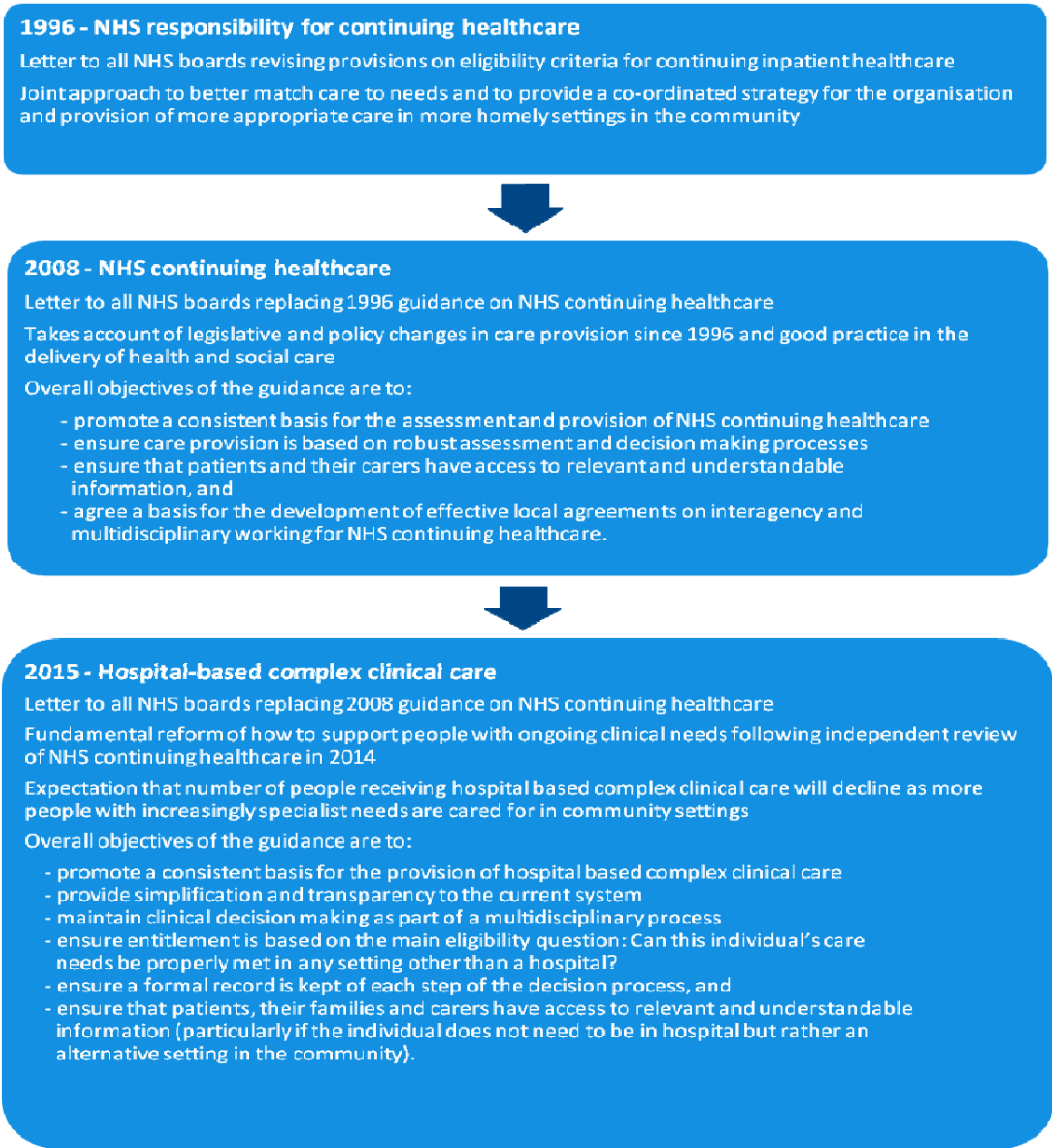
About this review

6. Healthcare Improvement Scotland carried out this review of the HBCCC service in Edinburgh after an initial analysis of issues relating to these services following a complaint about care in a hospital facility in NHS Lothian. This report examines how well HBCCC services are currently being delivered in the Lothian area and makes a number of recommendations for the future. It focuses on facilities in Edinburgh, but has wider implications for other similar services across NHS Lothian and lessons for similar services across Scotland. The review includes an assessment of:

   • factors that can impact on the quality of care, including leadership, governance, safety and workforce

   • patient care, including approach to person-centred care, dementia and cognitive impairment, nutrition, falls prevention and pressure ulcer management, and

   • sustainability of services in the short and longer term and capacity for making sustained improvement in the quality of care.

7. The review was carried out by a multidisciplinary team of individuals working across health and social care in Scotland and supported by staff in Healthcare Improvement Scotland (Appendix 2). We gathered evidence for the review by:

   • analysing documents and reports, including evidence from NHS Lothian and other organisations such as the Mental Welfare Commission for Scotland

   • visiting four facilities across Edinburgh and interviewing key staff at:
     - Astley Ainslie Hospital
     - Ellen's Glen House
     - Ferryfield House
     - Findlay House

   • interviewing senior management, the senior clinical team and clinical staff involved in the care of complex frail older people and the psychiatry of old age

   • holding drop-in sessions for staff from the HBCCC service

   • setting up a confidential email address available for staff and patients to share their experiences, and

   • carrying out unannounced inspections to the frail elderly wards in each of the four facilities, using Healthcare Improvement Scotland methodology for the inspections of care for older people in acute hospitals.

8. Our report highlights examples of good practice in some wards and areas for improvement in others. There is scope for NHS Lothian to improve consistency in how the service is delivered across the four facilities we visited.

Part 1: Hospital-based complex clinical care

9. With an ageing population, advances in technology and a focus on caring for people closer to their own home, the way that the NHS plans and provides care for people with complex care needs has changed significantly over recent years. Over the last 20 years, the criteria that NHS boards must apply when providing HBCCC has changed (Exhibit 1).

10. In May 2015, the Scottish Government issued guidance to all NHS boards to ensure they provide the best care for people with highly complex clinical needs. NHS boards were required to implement the guidance by 1 June 2015. To support this, the Scottish Government guidance asked NHS boards to introduce a structured, multidisciplinary 3-month review process.

Exhibit 1: National context and criteria for complex care

1996 – NHS responsibility for continuing healthcare

Letter to all NHS boards revising provisions on eligibility criteria for continuing inpatient healthcare

Joint approach to better match care to needs and to provide a co-ordinated strategy for the organisation and provision of more appropriate care in more homely settings in the community

2008 – NHS continuing healthcare

Letter to all NHS boards replacing 1996 guidance on NHS continuing healthcare

Takes account of legislative and policy changes in care provision since 1996 and good practice in the delivery of health and social care

Overall objectives of the guidance are to:

- promote a consistent basis for the assessment and provision of NHS continuing healthcare
- ensure care provision is based on robust assessment and decision making processes
- ensure that patients and their carers have access to relevant and understandable information, and
- agree a basis for the development of effective local agreements on interagency and multidisciplinary working for NHS continuing healthcare.

2015 – Hospital-based complex clinical care

Letter to all NHS boards replacing 2008 guidance on NHS continuing healthcare

Fundamental reform of how to support people with ongoing clinical needs following independent review of NHS continuing healthcare in 2014

Expectation that number of people receiving hospital based complex clinical care will decline as more people with increasingly specialist needs are cared for in community settings

Overall objectives of the guidance are to:

- promote a consistent basis for the provision of hospital based complex clinical care
- provide simplification and transparency to the current system
- maintain clinical decision making as part of a multidisciplinary process
- ensure entitlement is based on the main eligibility question: Can this individual's care needs be properly met in any setting other than a hospital?
- ensure a formal record is kept of each step of the decision process, and
- ensure that patients, their families and carers have access to relevant and understandable information (particularly if the individual does not need to be in hospital but rather an alternative setting in the community).

11.   NHS Lothian is changing the way in which HBCCC services will be provided in line with national guidance. A number of strategic documents will underpin the development of complex clinical care in NHS Lothian:

- 'Our Health, Our Care, Our Future' is NHS Lothian's strategic plan for 2014–2024[5]
- Edinburgh Health and Social Care Partnership's strategic plan 2016–2019[6], and
- Edinburgh Health and Social Care Partnership's joint strategic needs assessment.

12.   Following publication of the Scottish Government's guidance in 2015, NHS Lothian revised its HBCCC policy, guidance and toolkit. These are now in the process of being implemented.

> Almost 190 patients, with a wide range of care needs, receive hospital-based complex clinical care in the four facilities reviewed in Edinburgh.

13.   Within Edinburgh, NHS Lothian provides HBCCC services at four facilities (Exhibit 2). A number of people who are currently in HBCCC facilities were admitted under previous eligibility criteria. A number of these patients no longer require this level of complex care. Plans are under way to help them find more suitable accommodation so they can receive more appropriate care and support.

14.   Throughout our review, we noted the range of different needs of the patients receiving HBCCC across the four facilities. This varied from those patients who needed help with daily living activities, such as washing and dressing, to those who were approaching end of life and who needed intensive 24-hour nursing care. It also includes patients with mental health old age, dementia and those with complex behaviours that challenge. The challenges in managing such a wide-ranging patient profile are described further throughout this report.

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[5] http://www.nhslothian.scot.nhs.uk/OurOrganisation/ourHealthOurCareOurFuture/Pages/default.aspx
[6] https://consultationhub.edinburgh.gov.uk/hsc/edinburgh-health-and-social-care-partnership-draft

Exhibit 2: Hospital-based complex clinical care facilities in Edinburgh

Type of facility	Wards/Beds	Number of patients as at 4 January 2016			
		Patients admitted to hospital under eligibility criteria from:			Patients no longer meeting criteria – waiting for discharge
		1996	2008	2015	
Astley Ainslie Hospital A community hospital providing rehabilitation services for adults and older people with: - acquired brain injury - stroke - orthopaedic injuries - limb amputation - progressive neurological disorders such as multiple sclerosis, and - hospital-based complex clinical care.	**McCallum** (frail elderly)* (18 beds)	1	10	1	1
	Fraser (frail elderly) (22 beds)	2	9	3	2
Ellen's Glen House Provides NHS complex clinical care specialising in adults and complex clinical care for frail older people, and older people with mental health problems with complex needs.	**Hawthorn** (frail elderly) (28 beds)	2	8	14	4
	Thistle (psychiatry of old age)** (30 beds)	7	20	0	0
Ferryfield House Provides NHS complex clinical care specialising in complex clinical care for frail older people, and older people with mental health problems with complex needs.	**Rowan** (frail elderly) (30 beds)	0	17	10	3
	Willow (psychiatry of old age) (30 beds)	5	12	7	0
Findlay House Provides NHS complex clinical care specialising in complex clinical care for frail older people, and older people with mental health problems with complex needs.	**Fillieside** (frail elderly) (30 beds)	0	15	7	1
	Prospect Bank (psychiatry of old age) (30 beds)	5	15	5	0
TOTAL		22	106	47	11
		186 (including patients waiting for discharge)			

Adapted from information provided by NHS Lothian

* hospital-based complex clinical care for frail older people with complex needs
** hospital-based complex clinical care for mental health old age, dementia and those with complex behaviours that challenge

Part 2: Governance, leadership and workforce

15.   The way that HBCCC services are planned and managed is changing across Scotland. The **Public Bodies (Joint Working) (Scotland) Act 2014** will integrate health and social care services and establish integrated budgets to fund services to meet the health and social care needs of communities. NHS Lothian will work with four separate local authorities: City of Edinburgh, Midlothian, East Lothian and West Lothian. The Edinburgh Health and Social Care Partnership has been established to bring together the strategic planning and operational oversight of a range of adult social care services currently managed by the City of Edinburgh Council with a number of community health and hospital-based services in Edinburgh currently managed by NHS Lothian. These arrangements came into effect on 1 April 2016.

16.   An Integration Joint Board has been established for Edinburgh City, operational from April 2016. Under this new integrated approach, NHS Lothian and the City of Edinburgh Council are working with the Integration Joint Board to develop an integrated model of health and social care. NHS Lothian's HBCCC governance arrangements are currently under review to reflect the changes in roles and responsibilities. The service will become part of the remit of the Edinburgh Integration Joint Board.

17.   In practical terms, this means that the Integration Joint Board will be responsible for commissioning services from NHS Lothian and the City of Edinburgh Council to ensure that people living in the area receive the best care and treatment in line with national and local policy. As the partnership develops, it is important that the future service is continually developed and reviewed.

> Relationships between clinical staff and management are positive and constructive in most areas.

18.   Important features to achieve a positive culture include strong leadership and good working relationships between clinical staff and their managers. As part of our review, we spoke with staff and managers about the culture within the HBCCC service. Senior clinical managers reported that there is a positive relationship with managers, with good engagement and communication across the whole service, particularly in relation to managing change. This included the following regular meetings and updates:

- HBCCC quality improvement group, service quality improvement teams and clinical manager groups for the service
- commercial and NHS staff discuss key issues such as joint policies
- an alliance group involving human resources, occupational development and education staff, across NHS Lothian and the City of Edinburgh Council, reviewing induction processes for new staff, training and development opportunities and the development of new integrated policies
- senior staff meetings with information disseminated to the units
- monthly senior charge nurse meetings with information shared at ward meetings, and
- staff bulletins and briefings used to communicate information electronically.

19. Across each of the four facilities we visited, similar team structures were in place. On each ward, unregistered nursing staff worked alongside registered nurses, with a deputy charge nurse and a senior charge nurse managing the teams. In terms of accountability, senior charge nurses report to the unit manager, who in turn reports to the clinical service development manager. The clinical service development manager reports to the Integration Joint Board/ Edinburgh Health and Social Care Partnership chief nurse, who ultimately reports to the NHS board's director of nursing. We were told that the unit manager visits each facility every week, and the clinical nurse manager visits every month. The unit manager also carries out a monthly senior management walkround in each of the facilities. Staff described strong management support being key to supporting the delivery of high quality care.

> *In Astley Ainslie Hospital, there was clear leadership from the deputy and senior charge nurses. They worked together across the two wards to ensure team working and support to meet the needs of patients.*

20. Staff reported feeling well supported by senior management. Staff spoke confidently about how to raise concerns or escalate issues with their senior managers. We heard of an open and supportive culture across the wards where staff felt safe and confident to speak up. Staff felt they had access to other managers as needed and felt listened to and confident that managers were responsive and would decide on any action to be taken. We noted good examples of documentation, including flow charts detailing the reporting and escalation process, and information folders with relevant staff contact details, kept in the ward areas.

21. While we did see some excellent ward-based leadership, we had concerns over the lack of leadership in some of the wards we inspected. For example, Hawthorn ward in Ellen's Glen House has had difficulty in the recruitment and retention of a senior charge nurse. This had an effect on the leadership in the ward with a lack of consistency in the approach to patient care. As well as leadership, staff require the appropriate level of knowledge, competencies and time to deliver effective care. The issues highlighted throughout this report will require NHS Lothian to understand further the training needs of its staff working across the facilities.

There is a culture of openness and willingness to learn from mistakes.

22. Ward staff told us they would escalate any clinical issues to consultant staff or allied health professional staff, as appropriate. Medical staff told us they would escalate an issue or concern to the clinical lead at the Western General Hospital, Edinburgh, if needed.

> *Staff from Findlay House shared a recent example of escalation from the psychiatry of old age ward (Prospect Bank) where six patients required constant observations at the same time. This was a very challenging period for staff; it involved increasing staff numbers to provide additional cover for each shift. Staff told us that senior management were very supportive to alleviate other pressures on staff at that time.*

23. NHS Lothian provided us with summarised information on complaints, concerns and compliments received about its HBCCC service. Overall, the numbers of compliments far outweighed the number of concerns or complaints and the overall number of complaints for the service is small. When significant concerns have been raised, they have been subject to detailed review. In the last 2 years, 22 compliments were received, and two complaints and two concerns were raised. Key themes associated

with compliments were care and attention, kindness and compassion, being involved, and a sense of peace.

24. Senior clinical managers told us that a local process is in place for managing when an issue or a complaint is raised. This involves discussions with patients, families and staff. If a more detailed investigation is required, staff are involved more formally in this.

> NHS Lothian has invested in the workforce but there is a need to continue to address pressures on the system in respect of staff vacancies, sickness absence and temporary staff.

25. The increasing complexity of patients in HBCCC facilities requires a workforce that has the right skills and sufficient time to meet these demands. NHS Lothian has made a significant investment in staffing across the HBCCC service. However, NHS Lothian, in common with other NHS boards across Scotland, is experiencing difficulties in recruiting and retaining the right staff. This has the potential to impact on the quality and continuity of care.

Capacity

26. Since February 2015, NHS Lothian has invested over £1.13 million in nursing staffing:

- £182,000 to upgrade staff nurse posts to deputy charge nurse posts in each ward across all HBCCC facilities in Edinburgh, to improve leadership capacity
- an additional 3.18 WTE healthcare support worker/nursing assistant posts
- a further £500,000 for additional staff nurse posts (12.5 WTE posts), and
- an additional £450,000 for 12 WTE additional staff nurse posts with the move of patients to Prospect Bank ward, Findlay House from Royal Edinburgh Hospital.

27. NHS Lothian is currently in the process of recruiting staff to the last remaining vacant posts, after which it is anticipated that the wards will be at full staffing establishment. The ongoing challenge will be to reduce the high level of staff absence and also to retain the staff who are in post as well as ensuring the appropriate skill mix across the facilities (Exhibit 3).

Exhibit 3: Nursing staff levels within HBCCC service in Edinburgh (as at 13 May 2016)

Facility Total	Ward WTE	Funded establishment in WTE inclusive of Band 7 and Band 6		Current establishment in WTE inclusive of Band 7 and Band 6		Vacancy in WTE	
		Registered	Unregistered	Registered	Unregistered	Band 5	Band 2
Astley Ainslie Hospital	Fraser (frail older people) 27.03	13.6	13.43	13.6	13.43	0	0
	McCallum (frail older people) 27.03	13.6	13.43	13.6	13.43	0	0
Ellen's Glen House	Hawthorn (frail older people) 34.24	15.62	18.62	13.62	18.62	2	0
	Thistle (psychiatry of old age) 32.32	13.67	18.63	10.3	17.71	3.37	0.92
Ferryfield House	Rowan (frail older people) 32.23	13.6	18.63	13.6	18.63	0	0
	Willow (psychiatry of old age) 37.56	14.37	23.19	12.13	23.19	2.24	0
Findlay House	Fillieside (frail older people) 32.1	13.6	18.5	13.0	17.01	0.6	1.49
	Prospect Bank (psychiatry of old age) 37.55	14.5	23.05	10.47	22.86	4.03	0.19

Information provided by NHS Lothian

Staff from across the four facilities reported that the introduction of the deputy charge nurse positions had helped to alleviate previous staffing pressures and this post also helps support the senior charge nurses. Deputy charge nurses are now classed as supernumerary (not included in the staffing numbers on a shift). In Ellen's Glen House's frail elderly ward, these permanent posts are in the process of being recruited to.

28.   Consultants, middle grade specialty doctors and GPs provide medical input to the four facilities we reviewed. This equates to 47.5 (4-hour) sessions each week covering all complex clinical care frail elderly and psychiatry of old age patients across the facilities. Since 2012, a number of medical workforce reviews have taken place, resulting in additional investments made of 4.5 whole time equivalents working across the HBCCC service. This includes 3.8 WTE speciality doctors, 0.2 WTE consultant psychiatrists and 0.5 WTE medicine of the elderly consultants providing support. Medical cover is managed through a team at the Western General Hospital, and from the Royal Edinburgh Hospital for psychiatry input. However, staff told us that the changing complexity in care and the introduction of the new structured, multidisciplinary 3-month review process for the service will bring additional workload and will require additional support.

29.   We were told that day-to-day medical support to the service is provided by middle grade specialist doctors. Over the past year, the medical cover across these facilities has been restructured and there is now dedicated medical cover for each. This equates to a specialty doctor working Monday to Friday at each facility, with four specialty doctors providing most in-hours cover between 08.00am–18.00pm, after which NHS Lothian's out-of-hours service provides cover. A GP practice is associated with two facilities (Astley Ainslie Hospital and Ferryfield House) and GP cover includes telephone support and visits when required. The other two facilities (Ellen's Glen House and Findlay House) are not supported by a GP practice. Medical cover within these facilities is arranged for the hours of 08.00am–18.00pm.

30.   The physiotherapy at home service, occupational therapy service and palliative care nurses provide ad hoc cover on an individual referral basis. The physiotherapy team is fully staffed and has been able to retain staff in post. Staff told us that they were able to refer to a physiotherapist as needed, and that the physiotherapist visits once a week.

31.   The occupational therapy service tends to provide most support to patients from the psychiatry of old age service, although there are occasional referrals from the frail older people teams. We were told there is a high turnover of occupational therapy staff. The full establishment of occupational therapist is 2.2 wte (Bands 3–7). This is being addressed by restructuring the posts to allow for staff rotation, for example staff would not just be covering continuing care wards. An additional Band 4 occupational therapist was about to start in Findlay House, providing cover 1.5 days each week, supported by a qualified occupational therapist. Ward staff reported that there was not a large amount of occupational therapy input.

32.   At present, social work support is provided through Social Care Direct (a central point for referrals to social work services) on a case referral basis. The senior management team confirmed this service will need to be reviewed given the change to HBCCC guidance.

Out-of-hours

33.   It can be particularly difficult to ensure the appropriate level of clinical support is in place during the out-of-hours period. We reviewed out-of-hours arrangements as part of our review:

    •   an on-call charge nurse rota is in operation for advice and support to ward staff at 07.00am–15.00pm and 24.00pm–08.00am Monday–Friday and weekends

- a pager bleep can be used to contact the on-call shift co-ordinating charge nurse or unit manager for any issues needing escalation, for example staff shortages

- no senior charge nurse staff are on shift overnight or at weekends

- staff can get direct advice and support from specialists, such as the infection prevention and control team, for any relevant issues that needed escalating

- we were told that there is good dialogue with the out-of-hours medical service, and staff routinely use anticipatory care planning and 'ceiling of care' documentation[7], and

- staff can also access additional advice or support from the consultants on call for medicine of the elderly at the Western General Hospital or Royal Infirmary of Edinburgh sites at weekends and out of hours, as well as from the Royal Edinburgh Hospital if required.

34. NHS Lothian's unscheduled care service provides out-of-hours primary medical care services across NHS Lothian from 18.00pm–08.00am Monday to Thursday, from 18.00pm Friday to 08.00am Monday, and on public holidays. We were told that five doctors (typically GPs) provide cover across Edinburgh. The service can be contacted for any patient's physical or medical issues. The GP or hospital doctor on call will either provide telephone advice or visit the unit, as needed. We were told visits typically take place within four hours. Staff in the psychiatry of old age wards can also contact an on-call consultant from the Royal Edinburgh Hospital for advice and support out of hours, for example if a patient was displaying stress or distress.

35. In 2015, 179 calls were made to the out-of-hours service from Ellen's Glen House, Ferryfield House and Findlay House (an average of one call every 2 days). Staff on the wards spoke positively of the out-of-hours service and told us they had no problems accessing this. However, some ward staff felt that, although generally very helpful, the out-of-hours support varied and depended on the individual responding to the call and what patient care was needed.

36. Staff noted that if there are staffing shortfalls, patient care would be prioritised. In such cases, staff may be moved into a ward from across the other facilities in NHS Lothian, and agency or bank staff may also be used. However, shortages in staffing can affect the time staff are able to spend with patients.

> *On one ward, staff spoke about instances of using one staff member instead of two when providing particular aspects of care due to staffing shortfalls. A patient's care plan may note that two staff members are needed to support a patient, for example in cases of aggression. Staff told us that after gauging a patient's mood, they may only use one staff member. Staff stressed that judgements are made on a daily basis and that patients or staff would never be put at risk.*

Use of temporary staff

37. NHS Lothian has acknowledged the impact that the use of bank and agency staff can have on the quality and continuity of care and the significant financial costs involved. For some patients, such as people with dementia, continuity of care is particularly important and helps to alleviate any stress or distress. Senior charge nurses and deputy charge nurses make sure that, where possible, the same bank and agency staff are used to help minimise risks.

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[7] Ceiling of care documentation takes account of a patient's medical prognosis, future hopes and fears, any palliative treatments needed and anticipatory care plans.

38. Staff reported that bank and agency staff are regularly used to cover sickness absence, maternity leave and annual leave. Staff noted that there are challenges in having high numbers of bank staff on shifts as this has the potential to compromise the quality and continuity of care. This was particularly evident in Findlay House which had the highest use of bank staff at the time of the unannounced inspection.

39. NHS Lothian confirmed that, on the day of the unannounced inspection to Findlay House's frail elderly ward, nine staff were on the ward: five who were substantive, two bank staff who worked regularly on the ward and two who were new to the clinical setting but worked with staff familiar with the setting. NHS Lothian's senior management team acknowledged that this ward had been particularly challenged for a period of time due to high sickness absence levels, staff vacancies and a high number of patients requiring additional care and support. NHS Lothian was actively working to resolve this through recruitment and retention of staff, and reducing the reliance on bank and agency staff as well as managing staff absence.

> *Patients, family members, carers and friends told us:*
>
> *'I feel that at times there is not enough staff - also, for example, when bank staff are on, there doesn't seem to be sufficient updates on the individual patients. Have been given a board to put important things that my mother likes, ie put TV on, and lots of times when I have visited my mum, it isn't on.'*
>
> *'They are short of staff all the time.'*
>
> *'Staff don't have the time to do the job well.'*

A number of workforce initiatives have recently been introduced to address challenges.

40. NHS Lothian recently agreed a new nursing recruitment process. Posts will be advertised for specific places of work, reducing the likelihood of recruits moving to other posts in other hospitals or specialties. From 15 May 2016, NHS Lothian is also introducing a number of initiatives to help to reduce workforce pressures. This includes introducing a blanket ban on agency nursing and using bank staff to cover shifts. There will also be a focus on recruiting to full staffing levels. Additional recruitment is taking place to help reduce reliance on bank and agency use, and ensure safe staffing, while recruitment to vacancies are progressed and staff absence levels are managed. This is closely monitored. Information provided by NHS Lothian showed that the actions being taken were helping to reduce sickness absence levels on all but one ward (Ferryfield House's psychiatry of old age ward).

41. In February 2016, NHS Lothian introduced e-rostering. This has made it easier to ensure that staffing rosters are more compliant and that leave is allocated appropriately to ensure adequate cover at all times. We heard that staffing levels are reported at the twice daily huddles and staff are moved to areas of greatest need.

> *We were told of a number of staff from HBCCC wards who were on secondment to St. Columba's Hospice, Edinburgh. Staff felt this would be very beneficial when the staff members return from their secondment to provide support to staff and to patients with palliative and end-of-life care needs.*

Sickness absence

42. The senior management team reported that sickness absence was an ongoing challenge (Exhibit 4). This averaged at 12.8%, though it was as high as 23% in Findlay House. This high level of absence at Findlay House coincided with a difficult period when staff moved from the Royal Edinburgh Hospital to Findlay House due to a ward closure. However, levels of sickness absence have been improving since November 2015.

43. NHS Lothian provided us with an action plan to support a reduction in sickness absence, including a sickness absence management timeline and risk assessments. These actions should help to support a reduction in sickness levels.

Exhibit 4: Sickness absence levels at HBCCC facilities in Edinburgh (as at January 2016)

Facility	Ward	WTE	Sickness	WTE absent
Astley Ainslie Hospital	Fraser (frail older people)	27.03	8.7%	1.3
	McCallum (frail older people)	27.02	13.6%	2.59
Ellen's Glen House	Hawthorn (frail older people)	32.31	14.53%	3.4
	Thistle (psychiatry of old age)	34.24	6.99%	0.99
Ferryfield House	Rowan (frail older people)	32.23	7.22%	1.5
	Willow (psychiatry of old age)	37.56	11.32%	2.75
Findlay House	Fillieside (frail older people)	32.1	16.48%	4.0
	Prospect Bank (psychiatry of old age)	37.44	23.77%	7.4
TOTALS		**259.93**	**Av 12.8%**	**23**

Adapted from information provided by NHS Lothian

Training and education

44. NHS Lothian told us that a training needs analysis is being developed along with 'clinical skills passport' work for the HBCCC service. The education lead and service innovation lead nurse are taking this forward. The needs analysis is identifying mandatory training requirements (e-learning, practical training and clinical skills) for all nursing staff groups within Edinburgh City Integration Joint Board.

45. NHS Lothian provided us with information on current activities, including:

- a designated specialist palliative care nurse provides a teaching programme for staff, including advanced care planning, palliative and end-of-life care, and a palliative care link nurse study day
- a specialist palliative care nurse visits the units to talk to patients and relatives, and review medications
- the Promoting Excellence programme is being implemented (a national framework for all health and social services staff working with people with dementia, their families and carers)
- a 2-day dementia skills workshop is provided for staff
- a number of initiatives in relation to dementia are under way, including staff carrying out dementia skills training and dementia link nurses on the wards, and
- the service innovation team is improving induction for registered and unregistered nursing staff.

46. NHS Lothian provided us with information on mandatory training. We were informed about a number of initiatives, including:

- senior charge nurses take responsibility for ensuring their teams have the necessary skills and knowledge, training and education
- staff can access the service innovation team, on-site training, attend study days and conferences, and use online training to keep up to date with their required competencies such as for palliative care and delirium
- registered nurses carry out training on dementia skills, use of syringe drivers and aggression management
- revalidation to demonstrate fitness to practise is now a nursing requirement
- staff development needs are identified through the staff appraisal and personal development planning process, and
- training records can be accessed for staff completing learnPro NHS online training and education modules.

47. The high use of bank and agency staffing also has implications in terms of training and education of staff. For example, staff reported that bank and agency staff were not trained in extended duties such as making up syringe drivers. This meant that staff from other wards had to come and help with this.

Recommendation 1: NHS Lothian must carry out further ongoing risk assessments, taking account of the findings in this report, to ensure the levels and skill mix of staff across hospital-based complex clinical care facilities meet the needs of its patients.

Part 3: Safe, person-centred and effective care

48. As part of this review, we assessed the degree to which the HBCCC service in Edinburgh is safe, person-centred and effective. This takes account of a number of aspects of care, including record keeping, assessments and care planning, and access to meaningful activities for patients.

> ## NHS Lothian should strengthen its approach to record keeping.

49. Staff across the facilities stated that there are pressures to keep documentation complete and up to date. They were aware that they were not always consistent in documenting and evidencing the person-centred care they delivered. They stated that dedicated time 'off the floor' to catch up on paperwork would be helpful. We were told that documentation had been identified as an area for improvement.

50. Work is under way to review the current care planning documentation as part of a wider review of NHS Lothian's care planning process. This is being tested as part of Astley Ainslie Hospital's patient care planning documentation. NHS Lothian provided us with its care planning documentation and risk assessment care planning booklet.

51. In three facilities inspected, documentation, although not always complete, was well organised and easily identifiable with the use of folder dividers. Documents were filed in chronological order which enabled patients' progress to be followed easily. An index page showed where documents were located in the folder. However, in the other facility, we found that documentation was disorganised. Section dividers were not used in the folders and many notes were not filed in chronological order. The documentation was difficult to follow and did not support effective care delivery. Not all the loose leaf pages had the patient's details entered. We found different versions of risk assessment bundles were in use. These contained different guidance for staff to follow, for example when to carry out reassessments.

52. Across the facilities inspected, we found some common themes for improvement relating to documentation. These included:

    - not all records were legible, dated or signed.
    - a number of sheets were found to be missing for several days from some folders, for example artificial nutrition charts and tracheostomy charts. This meant there was no evidence of care being provided.
    - gaps in nursing progress notes for some patients.

53. In one ward, staff were unable to locate one patient's health record. We discussed this with the nursing staff as a matter of concern. On following up this issue, we were told that the patient's health record had later been located that evening.

Do not attempt cardiopulmonary resuscitation

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

taken to have honest and open communication to ensure patients and their families are made aware of the patient's condition. However, in some cases, clinical staff may decide not to share this information as they feel it may cause too much distress for the patient and their families. This decision should be clearly documented in the patient health records.

55. We reviewed 27 DNACPR forms across all four facilities and found an inconsistent approach to completing these forms. Patients who had a DNACPR status were clearly identified on the patient status at a glance whiteboards in all areas. Of the DNACPR forms reviewed:

- the majority of patients had their form reviewed on transfer of care
- there was evidence of review for most of the DNACPR forms
- the majority of forms evidenced discussions having taken place with the patient or their family, and
- all forms were signed by a consultant or senior clinician.

Medicines reconciliation

56. The Chief Medical Officer (CMO) (2013)18 guideline states that when a patient is admitted to hospital for more than 24 hours, medicines reconciliation should take place. This should include a documented record of the patient's details and whether they have any allergies. Any medicines prescribed to the patient should only be listed after checking with two or more sources. This can be the patient, a carer, GP, pharmacy or a printed GP letter. There should also be a medicines plan for each medicine to indicate if the medication is to 'continue', 'stop' or 'be withheld'. It should be clear who has completed the form and there should also be evidence of a pharmacist review.

57. It is considered good practice to review medicines reconciliation on patient transfer. From the patient health records reviewed during our inspections, patients had medical transfer letters from their previous hospital. This listed the patient demographics, current medications, frequency, plan (continue, stop or withhold) and patient allergy status.

Pain assessment

58. We saw that NHS Lothian's patient care rounding sheet contained a prompt for staff to ask patients if they were in pain. However, it was not clear from the patient health records reviewed what pain assessment tools were being used, particularly for those patients who could not communicate verbally. We did not see a consistent approach to pain management across the four facilities inspected.

59. During the unannounced inspections, we saw one patient had a non-verbal pain assessment and treatment plan chart completed. This was usually evaluated monthly. However, it was unclear how a 'monthly' frequency had been determined. Pain assessments should be carried out at a frequency as determined by the patient's needs. We saw no link to the patient care rounding record.

Other assessments

60. Functional assessments use an 'activities of daily living' sheet to enable staff to record any care needs such as communication, moving around, personal hygiene and toileting needs. During the unannounced inspections, we saw mobility risk assessments and continence screening tools were fully completed for the majority of

patients. However, the outcomes of these assessments did not always inform care planning or patient care rounding.

Several types of assessment documentation are used and information is incomplete for both initial and ongoing assessments across a number of areas.

61. All older people admitted to hospital should have assessments carried out to identify any risks and care needs. These include assessments of cognition, nutritional state, risk of falls and risk of developing pressure ulcers. Information gathered to complete the assessments should be accurately recorded and should indicate the date and time these assessments were carried out. The accuracy of assessments and, where appropriate, the source of information is important as this can impact on other assessments and aspects of care. For example, accurate height and weight are required for both nutrition and pressure ulcer risk assessments.

62. During the unannounced inspections, we reviewed patient health records across the four facilities. We identified a number of areas where documentation needs to improve across our review (Exhibit 5). We noted different versions of risk assessment documentation were in use and not all assessments were complete:

    - The **4AT assessment tool**[8] is used to screen patients for cognitive impairment. Of the 28 records we reviewed, 22 had a 4AT completed. There was an inconsistent approach to the reassessment of patients due to lack of clarity in NHS Lothian's policy.

    - The **Malnutrition Universal Screening tool (MUST)** is used for nutritional screening. Of the 28 records reviewed, 20 had MUSTs correctly completed. MUST rescreening was usually carried out on a monthly basis rather than a weekly basis as indicated in local policy. We saw an inconsistent approach to rescreening which should be carried out if a patient's condition changes.

    - **Nutritional assessment** should be completed within 24 hours of admission or transfer. Nutritional assessments identify individual patients' needs and requirements. Of the 27 records reviewed, 18 had been fully completed.

    - **Oral health risk assessments** should be undertaken within 24 hours of admission or transfer. Of the 27 records reviewed, 23 had this completed.

    - To identify those at risk of falls, NHS Lothian states that **a falls risk assessment** is carried out for every adult patient admitted within 24 hours. Of the 28 records reviewed, 27 had a completed assessment. Reassessment was variable.

    - All patients should have a **pressure ulcer risk assessment** completed within 6 hours of admission to hospital. Of the 26 records reviewed, 22 patients had been assessed. However, it was not clear if this was within 6 hours of admission. From NHS Lothian guidance, it was unclear how often reassessment should be carried out and this varied between weekly and monthly. We found a number of pressure ulcer assessments had been calculated inaccurately.

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[8] This can include delirium, sometimes called acute confusional state, a common serious condition for older people.

Exhibit 5: Record keeping and patient documentation

Dementia, delirium and cognitive impairment

Positive aspects

- Some examples of clear documentary evidence of review, investigation and treatment of reversible causes for patients with delirium such as urinary tract or chest infections.
- Communication with family and patient about treatment plans.
- Observed staff managing a patient with distressed behaviour. Clear plans to guide care, limited use of medication to manage behaviours. Evidence of psychiatric input for advice on prescribing and review of the patient. Various interventions to manage behaviours.
- Observed two patients requiring one-to-one observations. Risk assessment and management form completed for both, setting out risks and rationale for observation. Both were completed and reviewed on a regular basis by medical staff. One-to-one observations were provided in a sensitive and caring manner.

Areas for development

- Patient known to the psychiatry service had evidence of ongoing delirium. Evidence advice was sought from psychiatrist. No request for a review of the patient despite distressed behaviour being managed by the use of medication. No evidence of the use of behaviour charts to identify triggers or to monitor effect of medication. Medication given within the prescribed doses, but reliance on it by staff to manage behaviour. No evidence of review of the effect of medication or of the prescription by medical staff.

Adults with Incapacity (Scotland) Act 2000[9]

Positive aspects

- Some of the 24 adults with incapacity certificates we saw were well completed and referred to the accompanying treatment plans.
- It is best practice for those patients with an incapacity certificate to have an accompanying treatment plan. All 24 certificates had this in place. However, we noted different versions of the treatment plan in use.

Areas for development

- Not always clear from patient health records if an assessment of capacity to consent was carried out, partly because not all patient health records were available at the time of inspection.
- No prompt in records for nursing staff to check and identify if a power of attorney was in place. Inconsistent approach by staff to check what powers were granted and what decisions could be made on another person's behalf. Some records did not have a photocopy of the full power of attorney document.
- Not all patient health records had the decision for the use of the adults with incapacity certificates recorded.

Nutritional care and hydration[10]

Positive aspects

- Staff reported it was easy to access services from the dietitian.
- Examples of good evidence of assessments and clear plans where dietetic input required.

Areas for development

- No statement about how patients' height and weight was obtained or measured.
- Not all patients had a usual weight recorded to measure any unplanned weight loss. However, many patients had been in hospital for a considerable period of time, so previous weights were available for staff to calculate a weight loss score.
- Inconsistent approach and not adhering to local policy on the review of oral care.
- Local policy states patients who are fed by a tube require oral care every 3–4 hours. Review of records showed number of days where no oral hygiene was offered or provided to these patients. One patient's oral care chart was not completed for 5 out of 6 days.
- Lack of referral for patients needing dietetic input.

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[9] An assessment of capacity to consent to treatment should be carried out where a cognitive impairment has been identified, as this will inform the decision on whether an adults with incapacity certificate is required.

[10] Nutritional care and hydration are essential components in the care of older people. As such, all elements of food, fluid and nutrition are essential to promoting the health and wellbeing of the patient.

63. Ensuring that patients have enough to eat and drink is a vital part of their care. During our inspection, we assessed arrangements at mealtimes across each of the four facilities and observed the following.

Mealtime arrangements

- All wards implemented protected mealtimes to ensure that patients can focus on eating and drinking.
- Across all wards, patients could choose to eat in the dining rooms and staff assisted them to do so.
- There was an inconsistent approach to mealtime preparation. Hand hygiene and the opportunity to use the toilet were not consistently offered to patients before meals were served.
- On one ward, patients were positioned appropriately, bedside tables were pulled into position and protective aprons were given out ahead of the meal being served.
- Mealtimes were generally well co-ordinated and calm.
- On some wards, meals were served one course at a time. This is good practice. Meals were kept warm in the food trolley until a staff member was available to help patients if required.

Assistance with meals

- Inconsistent approach to patients being offered fresh drinks with their meal. For example, in one facility, patients in the dining room were offered a choice of drinks. However, those patients being served their meals in their rooms were not offered a choice of drink with their meal.
- Patients were given help and support as needed when each course was served. Patients were not rushed with their meal.
- Some staff were seen to be proactive in checking that patients were managing and in offering encouragement, particularly when patients were eating in the dining rooms.
- Of the eight patients who completed our questionnaire to rate their care from a list of statements, four agreed 'I get help with eating and drinking if I need it.'
- Staff did not always go back to check on or encourage all the patients who were eating in their own rooms.

We saw good examples of a person-centred approach to patient mealtimes. We observed a student nurse giving out soup to patients in a kind and encouraging manner. All patients were offered their preference of having their soup in either a beaker or a bowl. Patients were also offered a choice of meal at the time of serving.

Access to snacks, meals and drinks

- Inconsistent approach to snacks being offered to patients. Staff told us snacks were available, but it was unclear what snacks were routinely offered or consumed by patients as they were not consistently documented on food record charts.
- Across all wards, we saw patients who were able to drink had jugs of water or diluting juice at their bedsides. We saw drinks being given out in beakers or

with a straw where needed. However, we found that although some patients had drinks on their tables, these were not always within reach.

- The majority of food record charts were incomplete and there was no recording of snacks.

Food and fluid balance charts

- Inconsistent approach to using patients' food and fluid balance charts across the four facilities. Completion of the charts was variable and some patients' charts were missing for some days.

Artificial nutrition

- Lack of accurate recording in the patients' health records for artificial nutrition across the facilities. No consistent artificial feeds documentation was used. At one ward, patients had an 'enteral feed bolus record' sheet in use, whilst other wards used a fluid balance chart.

- Some patients had no record chart to evidence what food or water had been given. Where charts were in use, these did not always clearly evidence that the full amount of prescribed artificial feeds and water had been given or what times these had been started and stopped. Therefore, it was not possible to evidence that patients had received the correct amounts of prescribed artificial nutrition.

Two patients were receiving artificial nutrition through a feeding tube. One patient had a feed recording chart in place which staff had started on the day of the inspection. However, staff could not find any completed charts to evidence artificial feeds and water given for either patient for any previous days. We asked a nurse where staff would normally record a patient's artificial feeds and water intake. We were told that staff only write 'feed' on the daily patient care rounding sheets. Amounts are not recorded elsewhere. They stated that they could not find any feed record charts to use on NHS Lothian's intranet. We spoke with ward staff who were unaware of the practice of not documenting the amounts of artificial feeds. When we discussed some of these issues with a different member of nursing staff, we were told that all artificial feeds should be fully documented, including the actual amounts of feed and water, in line with the dietetic feeding.

Oral nutritional supplements

- Across the facilities, we found an inconsistent approach to how nutritional supplements were used and recorded. For example:
  - one patient was on nutritional supplements. There was good evidence of this on the nutritional supplements sheet. There was good evidence of review by the dietitian.
  - one patient had nutritional supplement drinks on their bedside table. However, these were not prescribed on the patient's drug chart. No fluid balance chart was in place to document how much the patient was drinking.

Good arrangements are in place to identify patients at risk of falls, but record keeping and actions after a fall need to improve.

64. Across the four facilities we reviewed, we saw good identification of patients who were at risk of falls, following an initial assessment. This included being highlighted on the ward whiteboards, at nursing handovers and patient safety huddles, and displayed at the patient's bedside.

65. NHS Lothian described a number of different tools to ensure safe practice across the HBCCC service. Examples included the use of patient status at a glance whiteboards, safety briefs, huddles and staff meetings across wards, units and the service. The open dialogue across staff groups was evident with quality improvement team meetings resulting in sharing of potential safety issues, audits and discussion on quality indicators.

66. We found that the majority of patients had well-completed mobility assessments in their patient health records. Equipment was available to support the prevention of falls for patients who were assessed as being at risk of falling in hospital. This included pressure alarms and 'high/low' beds which could be lowered to ground level for patients at risk of falling out of bed. We also saw that patients had their own mobility equipment in their rooms such as walking frames.

67. Risk assessments were not always carried out to demonstrate that the measures being used were appropriate or evidenced consent for the measures being used. Care plans we reviewed also did not always include any evidence of the measures in use such as high/low beds. Where a falls risk was identified, it did not always prompt more frequent patient care checks.

68. If a patient falls in hospital, a post-falls care plan should be completed and the patient should be reassessed. We saw variable evidence of post-falls reviews and completion of the post-falls care plan in patient health records. For example:

   • one patient who had fallen whilst in hospital had a post-fall review documented in their health record and a post-falls care plan completed, but this did not trigger a reassessment of the falls assessment.

   • two patients were recorded as having fallen in hospital. For both patients, we found a completed post-falls checklist that included examination of the patient. The incidents were also recorded on NHS Lothian's incident reporting system. However, we did not see evidence of a falls reassessment taking place or the patients' care plans being updated.

69. Assessment of the safe use of bedrails is particularly important for patients with a cognitive impairment or who are distressed. Bedrails can restrict a person's ability to get out of bed and, unless properly risk assessed, can create further risks to patient safety. During the unannounced inspections, we found bedrail assessments were well completed across all four facilities. However, although these had been completed, it was unclear whether consent had been obtained from patients or their relatives and carers, as there was no record of documented discussion.

Record keeping for pressure ulcers needs to improve.

70. We identified a number of issues relating to pressure ulcers during our review. We have highlighted a number of areas where record keeping needs to improve. From some of the records we reviewed, it was not possible to be clear if the record keeping or the care provided needed to improve. As we explain throughout the report, good quality record keeping is important to help ensure high quality care.

Wound assessment charts

71. Wound assessment charts allow a clear plan of management to be developed to promote wound healing for each patient with a pressure ulcer. From the 28 patient health records reviewed, six patients were identified as having a pressure ulcer. National guidance for pressure ulcers states that: 'Health records should include evidence that patients with a pressure ulcer(s) have a full assessment of the ulcer(s) and their management plan is documented.' Although wound assessment charts were in place to record this information, not all were fully or accurately completed. For example, we found:

- one patient's wound assessment chart had several documented pressure ulcers which were all numbered the same. Therefore, it was difficult to identify which dressing was being applied to which pressure ulcer and the progression of the wounds.

- one patient had three wound assessment charts in place. Two of these had a date recorded to review the wounds. However, these were not documented as having been carried out. The patient should have been referred to a podiatrist in line with the NHS board's policy but this was not recorded as being done.

Care rounding/SSKIN bundles

72. Care rounding is when staff check on individual patients at defined regular intervals to anticipate any care needs they may have, for example positional changes, pain relief or needing the toilet. The frequency of patient care rounding is prescribed by the nurse responsible for the patient and should be based on the outcome of assessments and care planning.

73. As part of care rounding, nursing staff monitor the integrity of the patient's skin using the SSKIN bundle (skin, surface, keep moving, incontinence and nutrition). This prompts staff to check patients' skin more regularly and reduces variation in care practices. By checking the skin more regularly, staff can identify early signs of pressure damage. Across the facilities, we found that the SSKIN bundle had been incorporated into the patient care rounding record.

74. However, we found that the patient care rounding records were not always consistently completed over a 24-hour period. Across all facilities, we found some of the patient care rounding records showed that patients had not been repositioned for long periods of time. Some had been left in the same position for most of or all of an entire day. We spoke with staff who said that one of the patients could move independently. This had not been recorded in their patient care rounding record. We were told another patient could not move independently. Again, this had not been recorded in the patient's care rounding record.

Frequency of care delivery

75. We found it was unclear how the outcomes of patients' assessments and care plans informed the frequency of patient care rounding. For example, those who were identified as being at high risk of falls may require more frequent care rounding. Most records had a frequency recorded, but some were blank.

76. However, we found examples of gaps in the recording in their patient care rounding records of between 7–15.5 hours. We discussed this with a senior charge nurse. They acknowledged that the completion of patient care rounding documentation was their main concern. They had asked a practice educator to carry out some improvement work and education with ward staff. Of the eight patients who completed our

questionnaire to rate their care, three agreed that 'Staff check on me regularly to ask if I need anything.'

Access to specialist pressure relieving equipment

77.   Specialist pressure relieving equipment, such as therapeutic air mattresses, can be used as an aid to prevent pressure ulcers. Across the facilities, we saw wards had access to specialist pressure relieving equipment. However, where a risk was identified and the appropriate pressure relieving mattress was in use, patients did not always have a pressure relieving chair or cushion. The use of pressure relieving equipment was not always documented in patients' care plans or in the patient care rounding record.

Specialist tissue viability input

78.   During the unannounced inspections, we saw evidence that two patients who had required referral to the tissue viability service had this carried out. Both patients had advice from the tissue viability service documented in their patient health records.

Care plans did not always provide sufficient detail to guide care.

79.   Care plans are used to identify what interventions will take place to meet the identified needs and risks for the patient based on the outcomes of initial and ongoing assessment. They should be evaluated to demonstrate that the interventions are having the desired outcome and to reflect that these needs may change.

80.   We found an inconsistent approach to the patient care plans in use. Nursing care plans were in use for some aspects of care but not all as identified in the patients' assessments. Care plans did not always provide sufficient detail to guide care. We also found that some patients did not have any care plans in place and some care plans were blank or did not meet all of their identified needs. For example:

- two patients did not have a care plan for how their cognitive impairment needs would be met, and

- two patients did not have a care plan for personal care needs despite the activities of daily living assessments having identified that this was required.

81.   We saw that where care plans were in place, many were personalised with nursing interventions listed. For example:

- two patients had detailed care plans for the management of confusion and agitation. These provided a good level of person-centred detail to guide care. They captured information gained from the 'Getting to Know Me' document.

- one patient had a detailed care plan in place for managing continence. It detailed the type of continence aid used and the frequency that the patient should be offered the toilet.

82.   We found an inconsistent approach to the evaluation and review of patient care plans across the four facilities. We saw good examples where care plans had been regularly evaluated and updated (usually on a monthly basis) and progress notes showed evidence of a review of care along with documented changed interventions. However, we also found examples where there had been changes in the patients' needs, and their care plans had not been updated. For example, two patients had

care plans in place which had not been updated since July 2014 and February 2015 respectively.

83. As many patients receive end-of-life care in these facilities, anticipatory care plans are in place. Across all four facilities, we saw evidence of anticipatory care planning for patients. This anticipates significant changes in a patient's health and social care needs, typically those with a long-term condition, and describes action, which could be taken, to manage this. Some patients also had anticipatory prescribing ('just-in-case' medicines) completed. This is where the doctor prescribes drugs that may be required if the patient's condition deteriorates and prevents delays in the patient receiving the appropriate medication.

84. Staff told us that getting to know the patients and their families makes it easier to have difficult conversations with them. We found many examples of well-documented discussions by medical and nursing staff with either the patient or a family member. This included evidence of difficult discussions with patients' families or power of attorneys about anticipatory care planning.

85. To ensure good communication and information sharing, particularly with visiting staff, these plans are used to document patients' wishes (for example, do not resuscitate documentation). Out-of-hours staff knew to refer to the 'yellow sheet' which documents a patient's history and their treatment plan. Any end-of-life anticipatory medications were also written up such as for pain, anxiety or breathlessness.

86. An important part of this review also focused on the views of patients and their families. We found some examples of good practice and positive feedback from patients and their families but also some areas where improvement is needed.

Patients and families provided positive feedback and there was evidence of being involved in care but they also identified areas for improvement.

87. We collected feedback from patients and their families during the review (Exhibit 6).

Exhibit 6: Summary of patient and family feedback

Method	Positive feedback	Development issues
During our unannounced inspections, we spoke with 19 patients and seven relatives and carers.	• 'The staff are really helpful and keep us all happy.' • 'The staff are very friendly and caring. There is a lot of banter. They know what I like.'	• 'I would like more physio to try and strengthen my legs. Continuity of staff - too many changes. Good staff leave because of demands on them.' • 'Care very good, not enough of it. Shortage of nurses all the time.'
18 people completed our carer and visitor questionnaire across the four facilities.	• 17 stated that 'Staff are friendly and approachable.' • 11 stated that 'I feel fully involved in discussions about the care and treatment of the	• 'The staff in general are all very kind and helpful. The communication could be better regarding feedback and updating regarding

Method	Positive feedback	Development issues
	person I am visiting.' • 17 stated that 'Staff listen to my views and opinions about the care of the person I am visiting.' • 'Extremely thankful that an NHS facility such as this exists to care for [my relative]. As a nurse myself, I appreciate how important communication is between staff and patients and staff and family and this ward is second to none in delivering that and compassionate care to a very high standard in often very difficult and challenging conditions of care.' • 'The staff are extremely courteous, pleasant and helpful. Easily approachable. Have the patience to listen and deal with patient and provide advice. Keep up the good work.'	mum's concerns. Have also noticed staff members seem to be constantly stressed and tired and complaining there is just not enough staff. My mum is very uncomplaining and at times she is in the lounge with no drinks in front of her and slouching in her chair and no staff around to notice. In noting these points, I have to stress that we really do appreciate that mum is here and the care she receives is generally good.' • 'There is no stimulation for patients. Food is very bland/tasteless.' • 'Communication with family/relatives could be better. Often no trained staff around to talk to. Perhaps a named nurse can feed back information to relatives in a communication book in relatives' room or on specific day and time to ensure kept up to date. Folders at bedside often not up to date. Missing laundry is an ongoing issue, several items missing over several months, no real concern, seems to be accepted despite labelling [of clothing] and notices.'

88. Across the facilities inspected, there was some good evidence of patient and family involvement in care planning. For example:

   • one patient's health record documented the first meeting with the patient's next of kin and staff where anticipatory care planning and DNACPR status was discussed, amongst other things.

   • another patient's health record showed evidence of family involvement and regular discussions on aspects of patient care.

- in some patients' health records, patient and family involvement was not directly evidenced in the nursing care plans. However, discussions were documented in the progress notes.

- a patient noted 'I feel informed about my care and treatment and my family are kept up to date.'

89. We found examples where relatives were supported to be involved in decisions about the patient's care plan. For example, relatives could be involved in multidisciplinary team review meetings and case conferences. Charge nurse clinics used to be held in Ferryfield House for relatives to meet with the charge nurses. Although these stopped as staff felt that they saw families and relatives on such a regular basis on the wards, we were told that staff were considering reinstating them with the consultant also attending. However, in other patients' health records or care plans it was not clearly evident that there had been any involvement with the patient or family.

> NHS Lothian recognises the importance of delivering person-centred care. However, we found that clinical practices are variable and need to improve in some areas.

90. Person-centred care is about providing care that is respectful and responsive to individual personal preferences, needs and values and ensuring that patient values guide all clinical decisions. Staff from across all four facilities spoke confidently of delivering person-centred care, recognising the importance of getting to know individuals and recognising personal preferences.

91. NHS Lothian has implemented the national 'Getting to Know Me' document. This document enables patients and their carers to inform staff about personal information such as likes and dislikes and things that are important to them. It is particularly useful for patients who have dementia or other communication difficulties and allows carers to identify how they would like to be involved.

92. During our review, staff spoke of using 'Getting to Know Me' and also described using 'What Matters to Me'. This is a three-step approach that includes asking, listening and doing what matters to the patient. However, during the unannounced inspections, we found that use of both 'Getting to Know Me' and 'What Matters to Me' varied across the four facilities.

93. Some patients had very detailed documents completed by the family. Where these documents had been completed, the information was helping to inform care and interactions and meet patients' personal preferences. For example, one patient who wished to have a long lie was left in bed until late morning and, once up and dressed, was given their preferred breakfast of tea and toast. We found other examples where these documents were partially or not completed.

94. We saw other examples during the unannounced inspections of person-centred care.

- Patients and their relatives are encouraged to bring in photographs, belongings or small items of furniture. As a result, many rooms had a 'homely feel' with personal items such as flowers, plant pots, pictures, framed photographs, ornaments and bedding.

- Across the wards, open visiting hours were arranged to meet the needs of patients and visitors.

- Relatives are encouraged to come in during mealtimes to help patients with their meal, or to keep them company while they eat.

- Staff spoke kindly to patients and all interactions we saw between staff and patients were positive. We did not hear any inappropriate language used or patients being treated in a disrespectful manner at any of the wards we visited.

- We saw staff work with the family of a patient who had communication difficulties to provide reassurance to the patient if they became distressed.

- A key phrases sheet was created and displayed in the patient's room to keep other staff informed.

95. However, challenges with staffing levels, environment and processes are having an impact on staff being able to fully meet individual patient needs and to promote dignity and respect. This was reflected in some of the feedback we received from patients and carers. For example, one patient reported a long wait, after being wakened before breakfast, to get help with washing and dressing. A relative/carer stated that 'During afternoon visiting, staff have a half hour tea break at which time there is one person left on duty for all three corridors. It is therefore very difficult to get help.'

Responding to patients requiring assistance

96. During the unannounced inspections, we saw a variable approach to the use of patient buzzers and how these were answered across the four facilities.

- Not all patients had access to a call buzzer. We were told that this was because not all patients could use them. However, this did not always prompt staff to make additional checks on these patients.

- Three of the frail elderly wards inspected were noisy with buzzers ringing frequently and for lengthy periods. This was due to delays in ward staff responding. Of the eight patients who completed our questionnaire to rate their care, only one agreed that 'Staff always respond quickly if I need help.'

- In Astley Ainslie Hospital, although patients had buzzers in reach, we did not hear any ringing while we were in the wards. This was due to staff proactively anticipating patient needs and being visible around the ward area.

- Across the other facilities, we saw a lack of staff presence in the ward areas and we saw instances where some patients waited over 5 minutes until their buzzer was answered. For example, in the frail elderly ward in Ferryfield House, we intervened on two separate occasions to assist patients who were calling for assistance and had waited 5–10 minutes.

Patient activities/cognitive stimulation

More should be done to provide options for meaningful activity for patients.

97. Encouraging patients, who are able, to socialise and participate in meaningful activity while they are in hospital helps to keep patients active and to help stimulate and improve their physical and mental wellbeing. During the review, we were told about a number of approaches to offering activities and therapies for patients.

- Wards provide various activities such as massage, hairdressing, quizzes, barbeques, movie nights, art classes and music groups.

- Some wards had an activities co-ordinator, and others were in the process of recruiting. Those wards with an activity co-ordinator saw a positive effect as patients appeared to be less stressed and distressed when they were engaged in activities which were meaningful to them.

- All facilities had day rooms including a dining area, which we saw some patients using during our inspections.

98. However, during our review, feedback from staff across the wards noted that more options could be provided for meaningful activity for patients and relatives. We noted the challenge in supporting activities given the wide range of patients, from residential care patients benefiting from an activities co-ordinator, to those who were approaching end of life and requiring 24-hour nursing care. We identified a number of issues which need to be addressed.

- Despite being furnished as a homely setting with a fireplace, wall lights and pictures, the day room in the frail elderly ward in Findlay House was being used for storage and office space, and not for patient use.

- During the unannounced inspection to the frail elderly ward in Findlay House, patients were seen sitting in recliner chairs in the day room in front of the TV. We saw very little staff interaction or cognitive stimulation for these patients. Patients were positioned in a row rather than in a small group. These chairs were unsuitable for patients who may wish to or be able to mobilise independently as they were too high from the floor and were in a reclined position. Patients also did not have fluids within reach or buzzers available to use. One patient was on one-to-one observations and we saw limited interactions by staff. This would have been an opportunity to carry out activities with patients.

- During our unannounced inspections, some patients told us:
  - 'There is not enough mental stimulation for me.'
  - 'There is not a lot to do. No activities of any kind.'

99. Family members, friends and carers comments included a comment about lack of visual and aural stimulation for patients confined to bed. A family member also noted that lighting can be harsh for patients who are lying down and looking up at the ceiling. The family member went on to note that since providing the feedback, they had noticed changes at Astley Ainslie Hospital 'observing quiet time with diffused lighting'.

General findings on ward environments

Wards are homely but, due to the ward layout in some facilities, additional risk assessments and improvements are needed.

100. During our unannounced inspections, we looked at the ward environments across the four facilities. Generally, wards and corridors appeared clutter free. Wards were a mixture of single rooms, 2-bedded or 4-bedded bays. All rooms had ensuite toilets and sinks. All single rooms and bay areas had a television. In some wards, patients had their names written outside their rooms rather than door numbers.

101. Shower rooms and bathrooms were located off the ward corridors. In some of the wards inspected, we saw dementia-friendly pictorial signs to indicate shower and

toilet rooms. We saw some examples of improvements made to the ward environment to make them more dementia-friendly. This included some areas with contrasting coloured handrails along the ward corridor walls. This helps to make them more visible to patients with a visual or cognitive impairment.

102. We saw and heard from staff that the general ward layouts, particularly frail elderly wards, present significant challenges for staff delivering safe care, due to the single patient rooms and long corridors. This can, at times, make interactions with patients difficult. For example, when staff are in rooms delivering care to patients, they have reduced visibility to other patients and carers, and are less able to hear requests for assistance. This also raises safety concerns.

103. Staff at Astley Ainslie Hospital brought to our attention the potential risk to patients and staff should a fire occur due to outstanding recommendations from a recent Scottish Fire and Rescue Service inspection. NHS Lothian provided us with a detailed description of the controls and mitigations in place to reduce the danger posed by outstanding building works required at Astley Ainslie Hospital (Balfour Pavilion). It is not within our scope of expertise to comment further on the adequacy of these controls. However, we acknowledge that the NHS board's internal governance and risk management arrangements will continue to assess and monitor the highlighted risks.

Recommendation 2: NHS Lothian must standardise its approach to all care plans, assessments and reassessments ensuring that the appropriate documentation is fully and accurately completed.

Recommendation 3: NHS Lothian must ensure there is a consistent application of current clinical management standards and guidance for hospital-based complex clinical care patients.

Recommendation 4: NHS Lothian must ensure that the ward and hospital environments across the hospital-based complex clinical care service are appropriate to the needs of the patients, particularly for people with dementia and cognitive impairment.

Recommendation 5: Where appropriate, NHS Lothian must ensure continuing positive engagement with patients, including appropriate cognitive stimulation and activities for patients.

Implementation of these recommendations must take account of the additional points listed in Appendix 1.

Part 4: Sustainability and capacity to improve

> A number of short-term issues need to be addressed to improve the HBCCC service and ensure patients receive the care they need.

104. While NHS Lothian needs to design how the service will be configured over a longer term, there are more immediate issues. Some of these issues relate to improvements that are needed to the current service which we have highlighted in this report such as record keeping. There are also a number of patients who are currently receiving HBCCC and are no longer eligible under the most recent national eligibility criteria.

    • As at 4 January 2016, there were 11 patients receiving HBCCC in Edinburgh who are no longer eligible. Plans are under way to help them find more suitable accommodation to meet their ongoing care needs.

    • Outwith Edinburgh, a further 10 Edinburgh patients are in NHS continuing care facilities receiving HBCCC. All of these patients were either admitted under previous national eligibility criteria and are reviewed on a regular basis. The review dates for those patients receiving inpatient complex care or HBCCC varies depending on admission and previous reviews. NHS Lothian noted that, as there is no standardised process in place, this information was not easily available.

105. As well as developing the future shape of the service, it is important that plans for providing appropriate care for patients who are currently receiving HBCCC are in place. However, where new guidelines suggest they are not receiving the best care in the right setting given their condition, a decision about the best setting for these patients needs to be made in partnership with the patients and families involved. A clear plan is needed for how their complex needs would be managed. These are difficult and challenging times and require a shift in mindset from staff and families. Consideration will need to be given about transition, and what support patients and their families need, for example, rehabilitation and support from physiotherapists, occupational therapists and mental health professionals as appropriate.

106. Staff working in the HBCCC service will need ongoing support to allow them to develop their skills to meet the changing complexity and needs of patients.

> NHS Lothian has recognised that the HBCCC service is not sustainable in its current form.

107. NHS Lothian, in common with other NHS boards in Scotland and health systems in many parts of the world, is experiencing pressure on services due to changing demography and financial pressures. Multiple factors will impact on the future development of the HBCCC service. NHS Lothian must ensure it manages the potential impact on the quality of care for patients through this transitional period.

108. As we highlight throughout this report, the HBCCC service is facing increasing challenges due to difficulties in appointing and retaining the right staff, financial pressures and changes in the complexity and needs of the patients presenting to the service. Taken together, these factors mean HBCCC will need to change. With the introduction of integrated health and social care services, there should be opportunities to improve and develop the service in the coming years.

109. The HBCCC service in Lothian has been through a number of changes to date. In 2014, NHS Lothian assessed potential models of care for patients requiring inpatient continuing care. The paper highlighted the challenges facing the service and noted that the 2008 Scottish Government guidance for assessing eligibility for continuing care was implemented in Lothian in 2010. This resulted in reducing the length of stay for patients using the service and, increasingly, that the service was providing palliative care. The paper summarises the proposed HBCCC strategic approach for NHS Lothian as follows.

- Future demand on HBCCC will reduce because of the increasing ability of care homes and community services to provide care for people with much higher needs.

- Changes to the national guidance will significantly change the patient cohort eligible for HBCCC.

- Current bed provision is broadly maintained but the equivalent service is increasingly provided from care homes or joint facilities where NHS staff work with care home staff to provide care for a higher complexity of need than is currently provided. This will require the development of new facilities and changes to how people in care homes are supported by NHS staff.

- New services will need to be developed to support people with higher care needs to have these met at home (with community support and access to a step-up residential service) and in care homes (with in-reach from specialist NHS teams).

- People will be able to access a residential service which can meet their continuing care needs. This will increasingly be provided in facilities that are either jointly staffed by NHS Lothian and local authority staff or where NHS Lothian provides an in-reach service to the care home.

110. This paper informed NHS Lothian's strategic plan 2014–2024 ('Our Health, Our Care, Our Future') and the current work programme to increase community and residential capacity to reduce the number of patients who are experiencing a delayed discharge.

NHS Lothian has set a strategic vision for the HBCCC service and is working with partners to develop a comprehensive operational plan.

111. NHS Lothian's strategic plan recognises the scale of the challenge in seeking to deliver its strategic ambitions in the absence of a balanced financial position. It states that it has not been able to develop a financial framework capable of supporting the investment in acute infrastructure, capacity in primary care and community services in particular (to start addressing the national 2020 Vision), and to free up capacity to deliver changes in patient pathways. Within the context of a growing population and, particularly, a growing elderly population and, at the same time, more people with more complex needs requiring community and hospital support, the financial outlook presented to the NHS Lothian Board in December 2014 set out an extremely challenging financial position for 2015–2016 and 2016–2017. There is a risk that the tightening financial position for both the NHS board and council has an adverse impact on some of the positive steps we have highlighted in the report, including the increased investment in staffing.

112. NHS Lothian's strategic plan describes a model of healthcare services where more patients are able to live at home with a greater range of support from health and care

services, where specialist hospital inpatient provision is delivered through four key sites (Royal Infirmary of Edinburgh, Western General Hospital, Royal Edinburgh Hospital and St John's Hospital, Livingston) and where existing continuing care and other hospitals are replaced by modern, integrated care facilities.

113.   The **Edinburgh Health and Social Care Partnership draft joint strategic plan** (2016–2019) indicates that in order to develop whole system capacity plans, to provide the right mix of services, the partnership will evaluate the need for the development of an integrated care facility model to meet capacity requirements for the care and support of older people as part of the hospital-based complex clinical care review. It will work with the council housing team to deliver homes for older people with higher needs. A whole system approach will explore the capacity required for each function across hospital complex care, care home and wider community supports.

114.   In March 2015, a business process management and outsourcing company gave a presentation to NHS Lothian on capacity planning and bed modelling as part of the future planning for HBCCC. This provided information on the proposed care pathway for an integrated care facility[11]. NHS Lothian will reconsider this information against the potential for various models across the spectrum of care and support going forward.

Integration of health and social care services

115.   **The Public Bodies (Joint Working) (Scotland) Act 2014** will integrate health and social care services and establish integrated budgets to fund services to meet the health and social care needs of communities. NHS Lothian will work with four separate local authorities: City of Edinburgh, Midlothian, East Lothian and West Lothian.

116.   The Edinburgh Health and Social Care Partnership has been established to bring together the strategic planning and operational oversight of a range of adult social care services currently managed by the City of Edinburgh Council with a number of community health and hospital-based services in Edinburgh currently managed by NHS Lothian. These arrangements came into effect from 1 April 2016.

117.   The Edinburgh Health and Social Care Partnership draft joint strategic plan (2016–2019) sets out how the services for which the partnership is responsible will be delivered in order to achieve nationally agreed health and wellbeing outcomes. The Partnership's draft joint strategic plan identifies six key priority areas as:

- tackling inequalities
- prevention and early intervention
- person-centred care
- providing the right care in the right place at the right time
- making the best use of capacity across the whole system, and
- managing resources effectively.

The Integration Joint Board ratified the Partnership's strategic plan in March 2016.

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[11] NHS Lothian has highlighted that some of the bed configuration has changed since this bed modelling was completed.

118. Within key priority area 4, providing the right care in the right place at the right time, the plan states that a high priority is to agree an improved and consistent service model for frail older people and those with dementia. This will anticipate and plan for needs, be responsive, make community and home-based care the norm, avoid unnecessary admissions to hospital, and promote timely healthcare, social care and reablement to maximise independence. A redesign programme called 'Improving Older People's Care in Edinburgh' is being developed. This aims to develop community health and social care capacity for older people in Edinburgh and would also look at hospital reconfiguration.

119. A draft joint strategic needs assessment sits alongside the Partnership's draft joint strategic plan and provides an assessment and forecast of needs for health and social care services across the city as a whole and in specific localities. This considers options, planning the nature, range and quality of future services and working in partnership to put these in place. The Integration Joint Board ratified the Partnership's needs assessment in March 2016.

120. As part of implementing the Scottish Government's 2020 Vision, more care will be provided at home or in a homely setting. This means less reliance on acute hospital beds. This will impact on the number of staff and the skill mix. Shifting the balance of care means the deployment of resources between the acute sector, and community care and the use of the third sector, and will require planned change. In the short term, an affordable, sustainable, trained workforce needs to be put in place.

121. NHS Lothian's strategic plan states that a paper was submitted to NHS Lothian Board in October 2014 recommending that the 'house of care' approach should be supported. This would establish a more person-centred and integrated model of care for people living with multiple long-term conditions and others with complex care and support needs. This model is being developed in partnership with NHS Lothian, third sector organisations, the local authorities in Edinburgh and the Lothians, and people who use health and social care services. This approach is now being considered by the four Integration Joint Boards. Potential early adopter sites have been identified in each of the four areas and there are varying degrees of strategic endorsement.

122. As well as broader issues about demographics and staffing, there are other practical reasons why the service needs to change, including a lack of care home provision in the area and changes related to facilities:

- Ferryfield House's lease expires at the end of 2017
- a planned reduction of 25 beds in the Royal Edinburgh Hospital by the end of 2018, and
- Ellen's Glen House's lease expires at the end of 2022.

123. These changes have the potential to address some of the challenges staff face working in older buildings, particularly as they are delivering complex care. It should also help to address other geographical issues. For example, staff from Findlay House felt there was sometimes a lack of recognition and awareness of them. This was felt to be partly down to its physical location, and the lack of support and contact that comes from being part of a wider hospital structure. From the psychiatry of old age ward's perspective, there was a feeling of isolation as most services were based at the Royal Edinburgh Hospital, for example the 'hive', volunteer centre and library. There was also a feeling that, because it was a private finance initiative (PFI) building, any NHS estates and maintenance issues were not a priority.

Number of HBCCC beds available Projected capacity in hospital sites based on current lease arrangements				
Ward	**2015**	**2016**	**2017**	**2018**
Frail elderly	141	85	85	55
Psychiatry of old age	128	128	128	73
TOTAL	**269**	**213**	**213**	**128**

Information provided by NHS Lothian (February 2016)

124. We were told that, overall, there is a potential reduction of 141 beds with the planned changes to buildings. Edinburgh projected care home capacity, with expected new homes and closures (based on need) results in a net increase of 156 beds.

125. NHS Lothian's senior management team shared the outputs from a stakeholder workshop held in January 2016 to discuss the future of the service. Key messages from the workshop intended to inform the next steps in the development of the service included:

   • defining the model against new guidance (many of the patients have been in hospital for a number of years)

   • defining the number of beds to meet demand

   • developing a plan to reduce hospital places and shifting balance to community environments

   • developing robust systems for assessment, review and communications with patients and relatives (3-month review)

   • ensuring staff are clear about the pathway and expectations for review and discharge

   • having access to an appropriately skilled and flexible workforce

   • having adequate social work support, and

   • having appropriate community support for complex care that does not require a hospital setting.

126. Based on discussions with staff, there is more for NHS Lothian to do to make sure they are fully engaged and involved in these plans. We highlighted earlier in the report that we observed a positive and supportive culture across the service. The Edinburgh Health and Social Care Partnership and NHS Lothian should capitalise on this as plans for the service are developed. We were told that NHS Lothian's chief executive and the Integration Joint Board's chief officer had recently visited a number of the units and staff had been able to highlight the issues and hopes of the teams. The unit nurse manager was also aware of the issues discussed.

127. Senior clinical staff recognised that the needs of patients in the HBCCC service have changed, and that the staffing and skill mix required to support this needs to change too. A whole systems approach is required when looking at this new pathway of care. The impact of this and the links with other pathways will need to be considered. We were told that clarity is needed on what HBCCC actually means, and ensuring patients and families understand the type of care being offered by the service.

128. Staff we spoke with were aware in general terms that the viability of the HBCCC service was currently under review. They shared with us their concerns about the service continually changing, with the shift from long-term care, to continuing care, to inpatient complex care and now hospital-based complex clinical care. It is important that NHS Lothian works closely with staff involved in the HBCCC service as plans are being developed, not least so it is clear to everyone involved how to ensure that patients receive the best care in the right setting at the right time.

129. Staff across the service spoke of the patient case mix changing over recent years. The changing population means that patients are becoming older, frailer and have multiple co-morbidities. As a result, staff felt it was becoming harder to define what the service or model of care was. Most patients now admitted have complex issues and are receiving palliative care. Staff told us that, in many cases, patients were not expected to live longer than 6 months, so felt they were seeing much frailer patients for less time. The service is becoming more hospice care, with very sick patients with more complex care needs. Meaningful interactions with patients and families are lessening due to patients' length of stay shortening. This makes it difficult to build relationships. Being clear with relatives about what the service is for and managing expectations is crucial going forward. For those with mental health old age issues, such as dementia, the length of stay is longer. There is more potential for this group of people to be discharged to more appropriate environments, and work will be required to support these transitions.

130. However, a small number of patients are able to be discharged. Staff told us that it can be challenging to meet all expectations with the competing demands of patients being discharged, and providing palliative and end-of-life care to other patients. For example, at the time of our review, staff from one ward in Ferryfield House told us that, in the 30-bedded ward, three patients were being discharged, two were receiving end-of-life care, and all other patients were receiving palliative care. Although beyond the remit of this review, it is important that there is a better understanding of the skills and training needed in relation to palliative care in the HBCCC service and how this fits with the overall vision for the service.

> ## NHS Lothian has a number of quality assurance initiatives under way focused on improving the quality of care.

131. NHS Lothian has a number of initiatives focused on assessing the quality of care and informing areas for improvement (Exhibit 7).

Exhibit 7: Quality assurance activity in NHS Lothian

Quality assurance visit programme
• NHS Lothian's quality assurance visit programme looks at a range of patient experiences relating to the ward such as physical environment, food, infection prevention and control, and health and safety matters. These visits include lay representation (trained members of the public) and are seen as a valuable element of quality improvement. A checklist is used for each visit and action plans are produced in response to the findings. NHS Lothian provided us with a number of examples of ward inspection reports and action plans for 2015.

Mock older people in acute hospitals (OPAH) inspections,
• Local improvements are identified through mock older people in acute hospitals (OPAH) inspections, with action plans developed and monitoring taking place. These are carried out every year or more frequently if improvements are required. The service innovation lead nurse has a system in place to more robustly follow up action plans. We were provided with examples of action plans and 'OPAH awareness and preparedness' action plans from 2015 and audit cycle information for the HBCCC facilities. Staff are developing an 'OPAH toolbox booth', a place for staff to find and do necessary reading to enhance their knowledge. The mock OPAH inspections have demonstrated some improvement in the reduction in pressure ulcers and falls. Senior clinical managers identified barriers to implementing improvements. The lack of administrative support and staff skilled in interpreting and analysing data is a challenge. It was also recognised that the use of bank and agency staff can make it more difficult to implement changes.
Rapid feedback
• NHS Lothian provided us with a copy of the rapid feedback form currently used in the HBCCC service: 'dog and rose'. The tool is used to gain feedback once a year from patients and relatives about 'what we have got right for you and what we could do differently'. Staff across the facilities were familiar with this feedback tool. They reported that they review and respond to the suggestions received, making improvements where appropriate or practical. However, they felt that more frequent feedback from patients and families would be beneficial.
Quality Improvement Data System (QIDS)
• NHS Lothian reported that it uses the Quality Improvement Data System (QIDS) to collect data every month. An improvement facilitator is now in post to support community hospitals and the HBCCC service will have more quality improvement training over the next year. Some training has already taken place which has resulted in better scrutiny and now more accurate recording.
Clinical audit
• NHS Lothian reported that each clinical area completes an audit of clinical notes every month and these are collated by the service innovation lead nurse. NHS Lothian plans to use this information to inform future documentation development and review. The NHS board provided us with audit information from April–November 2015 from Ellen's Glen House and Ferryfield House.
• NHS Lothian described its medical audit programme. These baseline audits are carried out by medical staff looking at various aspects of care. These will be incorporated into a rolling audit programme in 2016 and reported to the quality improvement team.

132. NHS Lothian has a range of improvement activity also with the aim of helping to improve patient care (Exhibit 8). Staff reported that if they see something they could improve, they would either discuss with colleagues or make the change themselves. Staff spoke of feeling involved and informed about change, and supported by management staff when they wanted to make improvements.

Ward staff told us the facilities manager and unit manager provided a lot of support when they wanted to make the duty room in Findlay House a safe place for staff to carry out shift handovers. We were given another example in Findlay House of staff documenting times on the care rounding sheet which was attached to patients' bedroom doors. The unit manager felt documenting the times was a good idea and was going to implement this on other sites.

Exhibit 8: Quality improvement activity in NHS Lothian

Quality improvement and patient safety report
• An HBCCC report was produced in January 2016. This provided an update on progress (including trend graphs) with the quality improvement and patient safety work within NHS Lothian's HBCCC service. The report states that compliance levels are high, but there has been no external validation as yet from the quality improvement support team. The report states that, in late 2015, Ellen's Glen House's frail older people ward identified reduced compliance with care rounding, pressure area care, and food, fluid and nutrition. As a result, an improvement facilitator delivered education and awareness to all nursing assistants.
Quality improvement team
• The quality improvement team meets every 3 months. This is a multi-professional group with staff from all clinical departments. It reviews incidents, complaints, audit reports, training and action plans.
• The quality improvement team has recently set up a documentation link nurse forum to help improve compliance with documentation. Senior clinical managers and staff across the wards told us that the link nurse forum is a service-wide area of improvement work and they were aware of, or involved in, this work. Staff are being supported and encouraged to consider how practice can be improved. New risk assessment documents have been developed and are now being piloted.
• The service innovation team has been working to identify areas to improve patient care across the HBCCC service. Staff spoke highly of the service innovation team as a great resource and support for them.

133.   Staff recognised that they regularly carry out improvements and changes on an informal basis. However, they recognised that evidencing and documenting these changes needed improving. The teams are working on how this can be improved.

134.   Any significant changes to be made are brought to the attention of the senior charge nurses through the clinical managers. These are then discussed at the monthly charge nurse meetings, and then introduced to the ward teams. Staff meetings are used to discuss change, and briefings or emails are also used to communicate with staff. We were told about a number of improvement initiatives that had been recently introduced. These included:

- safety huddles and patient at a glance status whiteboards
- reminiscence digital therapy technology purchased to support improvements in patient engagement in activities
- introduction of the new e-rostering system

- Ellen's Glen House environment project - staff work to ensure patients' rooms are personalised for the individual and are decorated to represent their personality. The team won the national Patient Experience Network's National Awards (PENNA) in 2011 for their work on personalised decor. This is now being transferred to other hospitals across the country.

- Astley Ainslie Hospital's wards use of mindmaps (an idea that came from a recent dementia study day). Each patient will be supported (with family input) to develop their mindmap to capture their likes and dislikes and what matters to them.

- aiming to increase compliance with care rounding - this involved working with staff to explain the importance of care rounding and the process. It was recognised that this was done informally and documenting the improvements has been a challenge.

> **Recommendation 6:** NHS Lothian must ensure the ongoing and future development of the hospital-based complex clinical care service takes full account of the financial and workforce implications.

Appendix 1 – Recommendations

The recommendations are for NHS Lothian to take forward. Healthcare Improvement Scotland expects that these recommendations will be used by the NHS board to provide guidance and support for those working in HBCCC facilities to help them deliver the necessary improvements. Any learning points identified should be considered across other similar facilities in NHS Lothian.

We expect NHS Lothian to develop an improvement action plan to implement the recommendations. It is important that the recommendations are carefully considered and a detailed improvement action plan developed, with appropriate timescales, ownership, accountability and measures incorporated.

Governance, leadership and workforce

Recommendation 1: NHS Lothian must carry out further ongoing risk assessments, taking account of the findings in this report, to ensure the levels and skill mix of staff across hospital-based complex clinical care facilities meet the needs of its patients (see page 19).

Safe, person-centred and effective care

Recommendation 2: NHS Lothian must standardise its approach to all care plans, assessments and reassessments ensuring that the appropriate documentation is fully and accurately completed (see page 34).

Implementation of this recommendation must take account of the following points:

a. This should include assessments for cognitive impairment, nutritional screening and assessment, oral assessments, falls management and pressure ulcer care. NHS Lothian must ensure that measured heights and weights are accurately documented, with the date and time that these measurements were taken (if estimates are used, this should be stated and a rationale provided). Where an assessment is not thought to be appropriate, the decision should be recorded within the patient's health record. This is to comply with Standards for Food, Fluid and Nutritional Care (2014), Criterion 2.2; and Best Practice Statement for the Prevention and Management of Pressure Ulcers (2009), Section 2.

b. All nursing and medical documentation must be legible, dated, timed and signed. This is to comply with The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council (2015) and the Generic Standards of Record keeping Royal College of Physicians (2009).

c. Patients must have person-centred care plans in place for all identified care needs. These should evidence patient or carer involvement and be regularly evaluated and updated to reflect changes in the patient's condition or needs, for example use of 'Getting to Know Me' for patients with a cognitive impairment. This is to comply with Standards of Care for Dementia in Scotland (2011), pages 15 and 26; Standards for Food, Fluid and Nutritional Care (2014), Criterion 2.9; Best Practice Statement for the Prevention and Management of The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council (2015).

d. Care must be implemented according to patients' personalised care plans. This is to

comply with Best Practice Statement for Oral Care of Older People (2005); Standards for Food, Fluid and Nutritional Care (2014); and The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council (2015).

e. There should be full and accurate completion of patient care rounding records, which are informed from initial assessments and care planning.

f. Information gathered should inform individual patient care – the 'What Matters to Me' sheet is completed and used for all patients to inform care planning. This is to comply with Standards of Care for Dementia in Scotland (2011).

Recommendation 3: NHS Lothian must ensure there is a consistent application of current clinical management standards and guidance for hospital-based complex clinical care patients (see page 34).

Implementation of this recommendation must take account of the following points:

a. NHS Lothian must ensure guidelines on the management of delirium are available to all staff who care for acutely unwell people. This is to comply with Standards of Care for Dementia in Scotland, page 26.

b. NHS Lothian must ensure that current legislation, which protects the rights of patients who lack capacity, is fully and appropriately implemented. This includes consulting any appointed power of attorney or guardian. When legislation is used, this must be fully documented in the patient health record, including any discussions with the patient or family. This is to comply with Adults with Incapacity (Scotland) Act 2000, Part 5 - Medical Treatment and Research.

c. MUST assessments clearly identify the need for referrals to a dietitian. This process must include ensuring referrals are followed up and the patients are seen. This is to comply with Standards for Food, Fluid and Nutritional Care (2014), Criterion 2.6.

d. Patients receive appropriate mealtime preparation and adequate support and encouragement is provided to all patients as required. This is to comply with Standards for Food, Fluid and Nutritional Care (2014), Criteria 4.8, 4.1 (e) and 4.11.

e. Patients receiving artificial nutrition have this fully and accurately completed in line with local policy. This is to provide documentary evidence of nutritional care provided. This is to comply with Standards for Food, Fluid and Nutritional Care (2014), Criterion 4.1 (g); and the NHS board's own local policy for artificial nutrition.

f. When food record charts are commenced for patients who require them, they are fully and accurately completed and appropriate action is taken in relation to intake or output as required. This is to comply with Standards for Food, Fluid and Nutritional Care (2014), Criterion 4.1 (g).

g. Wound assessment charts and any related documentation are in place for those patients with a known pressure ulcer or break in skin integrity to support safe and effective care delivery. This must include recording the grade of any pressure ulcers and a clear plan of management. These must be appropriately and consistently completed and be easily accessible. This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 4; and The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council (2015).

h.   The elements of the SSKIN bundle within the care rounding record are consistently and accurately completed. This is to ensure that the frequency of repositioning is prescribed and that the result of skin inspection and any changes made to the repositioning regime are documented. The information gained from each element of the bundle should be used to inform other assessments to ensure appropriate care planning and delivery. This is to comply with Best Practice Statement for the Prevention and Management of Pressure Ulcers, Section 1, and The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives, Nursing and Midwifery Council (2015).

i.   Patients at risk of pressure ulcer development have timely access to pressure relieving equipment and are suitably positioned to minimise pressure, friction and shear and the potential for further tissue damage. This is to comply with Best Practice Statement for Prevention and Management of Pressure Ulcers, Sections 5 and 6.

j.   Patients who fall whilst in hospital receive 'essential care after an inpatient fall' or local equivalent and this is documented appropriately. This is to comply with National Patient Safety Advice Rapid Response Report (January 2011).

Recommendation 4: NHS Lothian must ensure that the ward and hospital environments across hospital-based complex clinical care facilities are appropriate to the needs of the patients, particularly for people with dementia and cognitive impairment (see page 34).

 Implementation of this recommendation must take account of the following points:

a.   Ward environment must comply with Standards of Care for Dementia in Scotland, page 26.

b.   Where patients cannot independently seek assistance, for example, by using a buzzer, there is a process in place to anticipate patients' needs and proactive person-centred care is provided.

Recommendation 5: Where appropriate, NHS Lothian must ensure continuing positive engagement with patients, including appropriate cognitive stimulation and activities for patients (see page 34).

Sustainability and capacity to improve

Recommendation 6: NHS Lothian must ensure the ongoing and future development of the hospital-based complex clinical care service takes full account of the financial and workforce implications (see page 43).

Appendix 2 – Review team and assurance group

Review team

Name	Role	Organisation
Dr Neil Prentice (Chair)	Associate Medical Director and Consultant in Old Age Psychiatry	NHS Tayside
Dr Adrian Baker	GP (on behalf of Royal College of General Practitioners)	NHS Highland
Suzanne Burns	Consultant in Care of the Elderly Medicine	NHS Fife
Jenny Gibb	Associate Nurse Director, Mental Health and Learning Disability Service	NHS Grampian
Trudi Marshall	Nurse Consultant Older People	NHS Lanarkshire
Fraser Tweedie	Public Partner	Healthcare Improvement Scotland

The review team was supported by a number of Healthcare Improvement Scotland staff.

Assurance group

Name	Role	Organisation
Alan Gray (Chair)	Director of Finance	NHS Grampian
Dr Gordon Canning	Consultant Physician, Palliative Care	St Andrew's Hospice/ NHS Lanarkshire
Jane Douglas	Principal Assistant Social Care and Health/ Group Manager	Scottish Borders Council
Karen Goudie	Improvement Advisor	NHS Fife
Tony Wigram	Head of Health and Safety	Scottish Ambulance Service

Appendix 3 – Methodology

The unannounced inspections to frail elderly wards were conducted on **Tuesday 9 to Friday 12 February 2016** as follows:

- **Ellen's Glen House** - Tuesday 9 February 2016
- **Astley Ainslie Hospital** - Wednesday 10 February 2016
- **Ferryfield House** - Thursday 11 February 2016, and
- **Findlay House** - Friday 12 February 2016.

A senior inspector led the team and was responsible for providing advice and guidance, including in relation to the findings. The team was made up four inspectors, one clinical partner and one public partner, with support from a project officer.

During the unannounced inspections, we spoke with staff and used additional tools to gather more information. In all wards, we used a formal observation tool and the mealtime observation tool, where appropriate. We carried out nine 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 20 minutes.

We also carried out patient interviews and used patient and carer questionnaires. A key part of the public partner role was to talk with patients about their experience of staying in hospital and listen to what is important to them. Across the facilities we spoke with 19 patients and seven relatives during the inspections. We received completed questionnaires from eight patients and 18 family members, carers or friends.

As part of the inspection, we reviewed patient health records to check the care we observed was as described in the care plans. For this inspection, we reviewed all patient health records for cognitive impairment, food, fluid and nutrition, falls and pressure ulcer care. We also reviewed the patient health records for DNACPR forms and medicines reconciliation.

You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Officer on **0141 225 6999** or email **contactpublicinvolvement.his@nhs.net**

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