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Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Borders General Hospital
NHS Borders

22 - 23 November 2022

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About our inspection

Background

Taking account of the changing risk considerations and sustained service pressures, in November 2021 the Cabinet Secretary for Health and Social Care agreed adaptations to Healthcare Improvement Scotland's inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. To minimise the impact of our inspections on staff delivering care to patients, our inspection teams are carrying out as much of their inspection activities as possible through observation of care and virtual discussion sessions with senior managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records. Further information about the methodology for acute hospital safe delivery of care inspections can be found on our website.

New infection prevention and control standards were published in May 2022. These are applicable to adult health and social care settings and replaced the healthcare associated infection standards (2015). In May 2022, the chief nursing office contacted all health boards to inform them Healthcare Improvement Scotland will use these standards as a basis for inspection after a three month implementation period to embed the new standards. The implementation period concluded on Monday 8 August 2022. These standards have been used to inform infection prevention and control related requirements within this report.

Our focus

Our inspections consider the factors that contribute to the safe delivery of care. In order to achieve this, we:

- observe the delivery of care within the clinical areas in line with current standards and best practice
- attend hospital safety huddles
- engage with staff where possible, being mindful not to impact on the delivery of care
- engage with management to understand current pressures and assess the compliance with the NHS board policies and procedures, best practice statements or national standards, and
- report on the standards achieved during our inspection and ensure the NHS board produces an action plan to address the areas for improvement identified.

About the hospital we inspected

Borders General Hospital is a district general hospital situated on the outskirts of Melrose. It has 209 beds, plus intensive therapy beds and offers a wide range of healthcare specialities.

About this inspection

We carried out an unannounced inspection to Borders General Hospital, NHS Borders on Tuesday 22 and Wednesday 23 November 2022 using our safe delivery of care inspection methodology. We inspected the following areas:

- emergency department
- intensive care unit
- high dependency unit
- ward 4
- ward 6
- ward 7
- ward 9
- ward 12
- ward 14, and
- ward 17.

We also inspected the public and staff communal areas of the hospital.

During our inspection, we:

- inspected the ward and hospital environment
- observed staff practice and interactions with patients, such as during patient mealtimes
- spoke with patients, visitors and ward staff (where appropriate), and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Borders to provide evidence of its policies and procedures relevant to this inspection. The purpose of this is to limit the time the inspection team is onsite, reduce the burden on ward staff and to inform the virtual discussion session.

On Thursday 1 December 2022 and Thursday 5 January 2023, we held virtual discussion sessions with key members of NHS Borders staff to discuss the evidence provided and the findings of the inspection.

The findings detailed within this report relate to our observations within the areas of the hospital we inspected at the time of this inspection.

We would like to thank NHS Borders and in particular all staff at Borders General Hospital for their assistance during our inspection.

A summary of our findings

Our summary findings from the inspection, areas of good practice and any requirements identified are highlighted below. Detailed findings from our inspection are included in the section 'What we found during this inspection'.

At the time of inspection, Borders General Hospital, like much of NHS Scotland, was experiencing a significant range of pressures including increased hospital admissions, increased waiting times in admission units and reduced staff availability. We observed that although there were staffing challenges, staff responded positively to deliver effective patient care and we observed multidisciplinary teams working collaboratively to meet patient needs.

We observed the use of safety huddles to assess if care areas within the hospital site were 'safe to start' on the day. The safety huddles we attended appeared effective, all departments were represented and we observed staff engaging well. During the huddles staff adopted a person-centred approach, prioritising wards with the highest levels of patient risk and discussing how these risks would be managed and mitigated.

The senior hospital managers displayed good oversight, understanding of their clinical areas and the wider system pressures across the hospital. We observed senior management teams exploring new ways to address the staffing challenges and high levels of patient occupancy.

Care was person-centred and patients were treated with dignity and respect. There was a clear staff focus on the provision of safe and compassionate care for patients throughout the hospital. Staff told us that they were well supported by leadership and were able to raise concerns.

We also observed a person-centered approach to workforce planning, such as supplementary staff being allocated to wards they were already familiar with to ensure continuity of care.

Areas for improvement highlighted within this report includes patient mealtimes, documentation of care, compliance with hand hygiene and the poor state of repair of flooring throughout the hospital.

What action we expect the NHS board to take after our inspection

This inspection resulted in six areas of good practice and five requirements.

We expect NHS Borders to address the requirements. The NHS board must prioritise the requirements to meet national standards. An improvement action plan has been developed by the NHS board and is available on the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org

Areas of good practice

Domain 1

1 Infection and prevention control measures were in place at all of the major entrances to the hospital (see page 9).

2 We observed that the individual hospital teams were working together to provide the right care in the right place in line with Scottish Government emergency department signposting and redirection guidance (see page 9).

Domain 2

3 We observed positive and respectful interactions between patients and staff patients were treated with kindness and compassion. We observed that some staff would take the time to ensure patients were well informed about their treatment or any delays to treatment (see page 10).

Domain 5

4 We observed examples of good teamwork and communication across the multidisciplinary team, with a good understanding of their patients' health care needs (see page 14).

Domain 7

5 We observed an open and transparent approach with effective communication from both the hospital senior management team and ward staff throughout the inspection, including at safety huddles. There was documented evidence of updating staff, as well as a focus on their wellbeing (see page 16).

Domain 9
6 The hospital's senior management team were working to find innovative ways of addressing the challenges of staffing and improving patient movement through the hospital. Staff described being well supported by the senior management team (see page 18).

Requirements

Domain 5
1 NHS Borders must ensure that patient mealtimes are managed consistently and that patients receive adequate support at mealtimes (see page 14). This will support compliance with Food, Fluid and Nutritional Care Standards (2014) Standard 4.
2 NHS Borders must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes risk assessments, care and comfort rounding charts and fluid balance charts (see page 14). This will support compliance with relevant codes of practice of regulated healthcare professions.
3 NHS Borders must ensure that all staff carry out hand hygiene and use personal protective equipment in line with current guidance (see page 14). This will support compliance with National Infection Prevention and Control Manual (2022).
4 NHS Borders must ensure that the environment is in a good state of repair and maintained to support effective cleaning (see page 14). This will support compliance with Infection Prevention and Control Standards (2022) Criterion 8.1.

Domain 7
5 NHS Borders must have a system in place to ensure that all reported staffing risks are reviewed and responded to within agreed timescales. This is to comply with staff and clinical governance (see page 17). This will support compliance with preparation for the Health and Care (Staffing) (Scotland) Act 2019 (2022).

What we found during this inspection

Domain 1–Key organisational outcomes

- Quality indicator 1.2–Fulfilment of statutory duties and adherence to national guidelines

Infection and prevention control measures were in place with information at all the major entrances to the hospital. We observed hospital teams working together to provide the right care in the right place in line with Scottish Government emergency department signposting and redirection guidance.

We observed appropriate infection prevention and control measures in place. This included pre-admission respiratory screening questionnaires, appropriate use of personal protective equipment (PPE) and an enhanced COVID-19 testing regime. The hospital continues to test asymptomatic patients who, after a risk assessment, are still considered to have been at a high risk of exposure and may in turn present an infection risk to other patients.

Volunteers were present at the entrances of the hospital directing people to the correct place and reminding them to use the alcohol based hand rub and face masks provided. We also observed posters promoting this throughout the hospital.

We observed that the emergency department had clear signage relating to COVID-19, asking patients to report if they were experiencing any COVID-19 related symptoms. The department had separate cubicles and rooms available to isolate symptomatic patients until COVID-19 results were confirmed.

At the time of our inspection, staff reported that the emergency department was working within its expected capacity. However, staff shared with inspectors that they had experienced significant challenges over recent weeks related to high attendance and high occupancy rates. The national target for accident and emergency waiting time at the time of inspection was 95% of patients to wait no longer than four hours from arrival to admission, discharge or transfer for accident and emergency

treatment. In the published NHS Performs - weekly update of emergency department activity and waiting time statistics 75.5% of patients were seen within four hours for the week ending 20 November 2022. The longest wait on the day of inspection was 17 hours and 49 minutes. We observed the department to be calm and well organised with 11 patients waiting.

During our inspection we observed hospital teams working together to provide the right care in the right place in line with Scottish Government emergency department signposting guidance. Patients could be redirected, for example, to the Borders Urgent Care Service (BUCCS) or Borders Emergency Care Services (BECS) to be seen by a general practitioner or advanced nurse practitioner.

Areas of good practice

Domain 1

1 Infection and prevention control measures were in place at all of the major entrances to the hospital.

2 We observed that the individual hospital teams were working together to provide the right care in the right place in line with Scottish Government emergency department signposting and redirection guidance.

Domain 2–Impact on people experiencing care, carers and families

- Quality indicator 2.1–People's experience of care and the involvement of carers and families

We observed patients experiencing care were treated with kindness and compassion in how they were supported and cared for. We observed many positive interactions, with staff treating patients with dignity and respect.

The patients we spoke with told us about the care they had received and of the friendliness, patience and understanding of staff. Patients described staff as responsive, attentive and supportive. Patients told us that they were able to get assistance when needed. All call bells, drinks and personal items were within reach. In most areas, we observed that call bells were answered promptly.

We observed that patients who required isolation were kept well informed. Some wards had precautionary measures in place for immunocompromised patients, or for when patients were awaiting laboratory results. This included COVID-19 tests.

Where patients were experiencing delays with elective care, patients told us that the reasons for delay had been clearly explained and they were kept well informed.

All staff interactions we observed were positive. There were multiple examples observed and heard throughout the wards and departments of friendly and caring exchanges. These were between staff and patients, staff to staff, including ambulance crews and support staff.

Area of good practice

Domain 2	
3	We observed positive and respectful interactions between patients and staff patients were treated with kindness and compassion. We observed that some staff would take the time to ensure patients were well informed about their treatment or any delays to treatment.

Domain 5–Delivery of safe, effective, compassionate and person-centred care

- Quality indicator 5.1–Safe delivery of care

We observed examples of effective teamwork and communication across the multidisciplinary team, with a good understanding of their patients' health care needs. Areas for improvement include patient mealtimes, documentation of care, compliance with hand hygiene, and the poor state of repair of flooring throughout the hospital.

The majority of care areas we inspected appeared well organised with evidence of effective multidisciplinary working. We observed efficient communication and prioritising of patient care needs, for example, during ward safety huddles, staff briefings, ward handovers and on information boards. Staff regularly shared safety information throughout the day allowing them to plan safe care and prioritise safety concerns.

In a number of the wards we observed there was a lack of senior charge nurses, with many areas being managed by band five staff nurses who were seen to be managing competently and effectively. We were informed by staff on the wards that there were several senior charge nurse vacancies. We observed that the majority of the wards were well managed with leadership oversight provided by the clinical nurse manager. We observed examples of good leadership in some areas including the intensive care unit.

In the intensive care unit, staff were keen to highlight improvement work to the inspection team which included a clear development plan for staff. Newly appointed

registered nurses had a folder with evidence of various competencies that required to be completed. There was additional learning also arranged from visiting specialities to develop and enhance care planning.

In some wards the hospital had rearranged the capacity of some areas by adding additional rooms to the ward area. Staff we spoke with told us these beds had created some challenges around patient observations of care. However, this did not impact on the quality of care provided. In most instances we observed that the physical spacing of beds complied with current guidelines. There were some instances where this was compromised if the patients chose to place their bedside chairs next to each other. Inspectors highlighted this to the ward staff at the time of our inspection.

Borders General Hospital uses an enhanced care observation tool (ECO) to assess how much care a patient needs to ensure that they are safe and well looked after. Patients requiring enhanced observation had this documented in an ECO tool, prompting staff to ensure certain duties had been completed.

We observed a high number of patients requiring enhanced care observations. This was highlighted at the staffing huddles as evidence of the high acuity of patients and the resulting request for extra staff to look after them.

Where we had the opportunity to review adults with incapacity certificates and copies of power of attorney within patient notes, they were complete and up to date. These are legal documents which assist the patients, their family and staff to make decisions about the patients care when the patient is unable to do so independently.

We observed each ward had a swipe card entry system for staff and an exit push button system for patients and visitors. There were no locked wards at the time of this inspection. We observed an incident where a patient gained entry to a fire escape from the ward due to a failure in the locking mechanism. The patient was found by ward staff from another area and quickly escorted back to their own ward. This was highlighted immediately, and we were told the door would be repaired as soon as possible. We observed that the door had been repaired during our time at the hospital.

We observed several patient mealtimes across a variety of wards. The majority were well organised and staff knew the patients' dietary needs, including if they were allowed to eat or were nil by mouth. We observed some good examples of well managed mealtimes and staff helping patients with their meals. However, in one area we observed mealtimes were not well managed with a lack of coordination. Meals were left for a length of time on bedside tables waiting for staff to be available to assist patients who required help. We observed some patients requiring assistance were left in bed with no pre-mealtime preparations observed, such as hand washing or help to sit.

We raised these issues with the senior hospital managers and returned to the area the following day to observe the mealtime arrangements. We found that significant improvements had been made. There was better organisation of the meals being delivered and the staff were more attentive to patients who required assistance. A requirement has been given to support improvement in this area.

During our inspection, patients we spoke with told us that they were well cared for. This was also reflected in our observations. The patients looked well cared for, comfortable and their bed spaces were tidy and clean. A number of patients were dressed in their own clothes and those patients we spoke with told us they had received the help they needed with personal care.

We observed that care was person-centred and patients were treated with dignity and respect. However, we observed the impact of staffing pressures on the delivery of care. For example, care and comfort rounding recording was not always carried out. Care and comfort rounding is when staff review the care of individual patients at defined regular intervals to anticipate any care needs they may have.

In several wards inspected, we observed long periods of time between entries in the comfort rounding documentation. Individual falls and nutritional assessments had not been completed. We observed staff had a lack of knowledge about which charts should be available at the bed space. Our findings reflected that of the hospital's own auditing system, where these areas had already been identified as requiring improvement. We discussed this with the senior leadership team who reported that they were working to address these areas. A requirement has been given to support improvement in this area.

We observed that in some wards there were patients receiving anticipatory medication and staff were renewing medications in a timely manner. Anticipatory medication is used in end of life care when patients have difficulty or cannot swallow tablets. We observed staff providing analgesia for patients when they required it.

Dementia specialist nurse and allied healthcare professionals (AHPs) such as physiotherapists, occupational therapists and dieticians were visible on some wards. We observed interactions which were positive and person-centred. The staff reported and we observed from the data submitted that there were AHP vacancies.

In one area inspected, staff highlighted a higher than expected number of falls had occurred in a short period of time. We discussed this with senior hospital managers who were already aware of this, and were able to provide evidence of staff reporting the falls and measures taken to reduce further falls within that area.

When patients required isolation facilities for infection control, these were met. For example, the emergency department had a small number of identified single room areas for patients to await COVID-19 test results if they were symptomatic. Each ward area had side rooms where patients could be isolated if needed. One ward had

two bays closed due to COVID-19 and all side rooms in use for isolation, or patients' clinical condition.

The intensive care unit had a number of side rooms and an area which could provide isolation for patients. This included those undergoing aerosol generating procedures. All rooms and bays being used for isolation had signage in place.

In order to minimise the risk of cross infection, standard infection control precautions (SICPs) should be used by all staff at all times. One of the key precautions is practising good hand hygiene. This helps reduce the risk of the spread of infection. We observed that alcohol based hand rub was readily available on all wards, departments and at all hospital entrances for staff and visitors to use.

The majority of staff we observed were compliant with hand hygiene. However, we identified areas where hand hygiene opportunities were frequently missed. This related to the overuse of gloves and not changing them between patients or tasks. Therefore, not carrying out hand hygiene at the correct moments. This was raised with and addressed by the senior charge nurse at the time of our inspection. We discussed this with the infection prevention and control team, who through their own audits were already aware of the issues. In the discussion session with senior hospital managers, we were told it was their intention to focus improvement work to support hand hygiene and the correct use of gloves in the areas where this had been identified as a problem. A requirement has been given to support improvement in this area.

We observed some staff were using PPE such as gloves and aprons appropriately. In all areas inspected there was a sufficient stock of PPE available, and it was stored correctly to prevent contamination.

Current guidance from the Scottish Government strongly recommends that staff who are moving around clinical and non-clinical areas within the hospital setting wear a fluid resistant surgical face mask or face covering. We observed staff across all disciplines who were wearing surgical face masks correctly.

Other SICPs such as linen, waste and sharps management minimise the risk of cross infection and must be consistently practiced by all staff. We observed the majority of areas were compliant with these precautions.

Throughout the hospital, the majority of care equipment was clean. However, the majority of large care equipment was stored in corridor areas. This included stand aids and hoists, clean linen storage trolleys and units. This caused the corridor of the wards inspected to appear cluttered. We discussed this with domestic staff who told us they have adapted practices to move items out the way to allow them to effectively clean. We observed that the majority of communal areas were being kept clean.

We also observed that there was inadequate storage throughout the hospital. This caused items to be placed on the floor which results in the cleaning of the area becoming more difficult. NHS Borders have told us they have plans to address this area.

In the wards we inspected, we observed a number of items of old and worn patient use equipment such as tables and chairs.

The environment must be in a good state of repair to support effective cleaning. We observed throughout the hospital wards that the flooring was in a very poor condition with a large amount of hazard tape in numerous places in main corridors, rooms and bays. This meant that the floor area could not be kept clean. We discussed this with senior hospital managers and were provided with an action plan to address this issue. The plan gave a broad outline of areas to be addressed within the financial year of 2022-2023. A requirement has been given to support improvement in this area.

Area of good practice

Domain 5	
4	We observed examples of good teamwork and communication across the multidisciplinary team, with a good understanding of their patients' health care needs.

Requirements

Domain 5	
1	NHS Borders must ensure that patient mealtimes are managed consistently and that patients receive adequate support at mealtimes.
2	NHS Borders must ensure that all patient documentation is accurately and consistently completed with actions recorded. This includes risk assessments, care and comfort rounding charts and fluid balance charts.
3	NHS Borders must ensure that all staff carry out hand hygiene and use personal protective equipment in line with current guidance.
4	NHS Borders must ensure that the environment is in a good state of repair and maintained to support effective cleaning.

Domain 7–Workforce management and support

- Quality indicator 7.2–Workforce planning, monitoring and deployment
- Quality indicator 7.3–Communication and team working

NHS Scotland continues to experience significant pressures compounded by staffing vacancies and recruitment challenges. Borders General Hospital provided workforce data which demonstrated high levels of vacancies, particularly evident within registered nursing and healthcare support workers staff groups. Despite these pressures, we observed good leadership, early recognition of emerging staffing risks, management of risks, clear communication and effective levels of care.

Nursing teams told inspectors that they were working with less that optimal staffing levels and the necessary skill mix to support the delivery of safe and effective care.

Despite staff advising of the less than optimal staffing, we observed communication was effective and staff were focused on the provision of safe and compassionate care for the patients. Staff told us that they were well supported by leadership and were able to raise concerns.

Workforce data was submitted for October 2022. This demonstrated a high level of vacancies, particularly within the registered nurse and healthcare support worker staff groups. Absence data provided for nursing, medical and AHP staff demonstrated well managed absence levels. Medical data for hospital sites across NHS Scotland is not easily accessible and therefore this resulted in a delay in receiving this.

Supplementary staffing includes substantive staff working additional hours, staff from the NHS boards' staff bank or staff from an external agency. Supplementary staffing was being used to support staffing gaps and clinical areas experiencing increased service demands.

We observed a robust approach to workforce planning, allocating supplementary staff who were familiar with the clinical areas where possible to ensure continuity of care. The clinical nurse manager told inspectors that they have a good understanding of current staff skills and knowledge, including those staff who worked regular supplementary shifts from the staff bank and external agencies. This supported the appropriate placement of staff.

Borders General Hospital uses a staffing template. The key principle of this template is to record the real time staffing risks, mitigations, and professional judgement which then determines a 'safe to start' position. Professional judgement is when the clinical staff use their expertise to assess staffing requirements to ensure safe and effective care can be provided. We observed that the staffing template did not align with patient complexity or dependency scoring. However, we observed staff

confidently voicing their concerns at the staffing huddles. This further supports open and transparent decision making.

We observed discussions around risks and how these could be mitigated, these were documented within the safety brief and reviewed over the day. Nursing and midwifery clinical staff were encouraged to make the decisions regarding staff movement and assign the staff resources to the areas of higher risk and priority. Clinical nurse managers had good oversight over these decisions.

The AHP team uses a toolkit which supports the identification of priorities and staffing risks. This feeds into the main staff huddle in the morning. At present there is not a system and process in place for capturing recurrent risks or themes within these teams. Management informed us that this is in development. Other than nursing and AHP teams, we did not observe any other staff groups document real time staffing, risks and mitigations. A requirement has been given to support improvement in this area.

Staffing risks are also recorded using the NHS electronic incident reporting system. NHS Borders has received reports on identified staffing risks. Staff are encouraged to report their concerns through this system. There is also a process in place to identify and report on themes. It was noted that there are significant outstanding reviews for these risks and senior hospital managers have acknowledged this. They have identified staff to focus on supporting this and they are working towards a resolution. We observed several initiatives to promote communication, an open and transparent culture within the hospital campus. For example:

- encouraging staff to report concerns on the NHS electronic incident reporting system
- daily safety brief to all staff which highlighted issues and actions and the availability of a range of staff groups for example, AHP and pharmacy staff
- transparency around the assessment of risk each day and what actions they had taken to resolve this where possible, and
- collaboration between all professional groups including the Scottish Ambulance Service.

Area of good practice

Domain 7	
4	We observed an open and transparent approach with effective communication from both the hospital senior management team and ward staff throughout the inspection, including at safety huddles. There was documented evidence of updating staff, as well as a focus on their wellbeing.

Requirement

Domain 7
5 NHS Borders must have a system in place to ensure that all reported staffing risks are reviewed and responded to within agreed timescales. This is to comply with staff and clinical governance.

Domain 9: Quality improvement-focused leadership

- Quality indicator 9.2–Motivating and inspiring leadership

The senior leadership team were working to find innovative ways of addressing the challenges of staffing and improving patient flow through the hospital. The staff huddles were well organised with good representation from the multidisciplinary team.

We observed the use of safety huddles to assess if care areas within the hospital site are 'safe to start' the day. The safety huddles we attended appeared effective, all departments were represented and we observed staff engaging well. Staff adopted a person-centred approach, prioritising patients with the highest risk factors and discussed how patient's care would be overseen and any patient care risks mitigated.

We found the senior management team to be very conscious of the difficulties facing the hospital and we were assured that they were constantly striving to find new and innovative ways of addressing them.

When we identified areas for improvement described earlier in this report, the senior hospital managers responded in an open and transparent manner. They had a good knowledge of the area of concerns raised, the staff involved, and had risk assessed and planned actions that were needed to address the concerns.

The majority of staff that we spoke with reported that they were well supported by the senior management team.

Senior hospital managers described some of the work underway to reduce the impact of high attendance numbers within the emergency department and high patient numbers within the hospital. This included a quality improvement method to help improve admission times in the emergency department and ensure more effective patient discharges from the hospital.

An internal evaluation by NHS Borders appeared to demonstrate the positive impact of the improvement work in improving patient flow through the hospital. Staff within the emergency department also shared their support for the improvements and their positive effect. However, it was highlighted that staff shortages where having an impact on the sustainability of the improvement work. We are currently unable to

comment definitively on how successful this approach will be as it is still in the initial stages of implementation and there is insufficient data to support an informed decision.

Another improvement NHS Borders is working on is the enhancement and development of the health care worker role. This includes developing the skills of the health care worker to reduce the workload of the registered nursing staff and allow more time for duties that can only be carried out by registered staff. At the time of our inspection senior hospital managers and staff told us they felt that the development of this role was having a positive impact in supporting the provision of care.

During the inspection we were provided with evidence of a series of safety audits, risk assessments and mitigations to support patient safety. Some of these were identified as part of this inspection. For example, in the area where a higher than expected number of falls had been identified senior hospital managers were able to provide evidence of this from the incident reporting system. We were also provided with evidence of significant adverse event reviews being carried out. These are used to better understand the reasons for the falls and if any learning could be shared to improve patient safety. The senior hospital managers described how any learning was escalated to a safety governance committee. In addition, any recommendations were circulated on safety dashboards to all areas in the hospital to support sharing learning from the reviews with the wider staff team.

Further action taken to support the improvement of falls management includes NHS Borders engagement with Healthcare Improvement Scotland to commence falls improvement work. This demonstrated a good example of incident and risk reporting being used to support quality improvement.

Area of good practice

Domain 9	
6	The hospital's senior management team were working to find innovative ways of addressing the challenges of staffing and improving patient movement through the hospital. Staff described being well supported by the senior management team.

Appendix 1 – List of national guidance

The following national standards, guidance and best practice were current at the time of this inspection. This list is not exhaustive.

- COVID-19: Endorsed Guidance For NHS Scotland Staff and Managers on Coronavirus (NHS Scotland, January 2022)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection Prevention and Control Standards (Healthcare Improvement Scotland, May 2022)
- National Infection Prevention and Control Manual (NHS National Services Scotland, July 2022)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing and Midwifery Council, October 2018)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, January 2016)
- Food Fluid and Nutritional Care Standards (Healthcare Improvement Scotland, November 2014)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Care of Older People in Hospital Standards (Healthcare Improvement Scotland, June 2015)
- Quality of Care Approach – The Quality Framework First Edition: September 2018 (Healthcare Improvement Scotland, September 2018)

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