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To drive improvement

Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Dumfries & Galloway Royal Infirmary

NHS Dumfries & Galloway

11–12 June 2025

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About our inspection

Background

In November 2021 the Cabinet Secretary for Health and Social Care approved Healthcare Improvement Scotland inspections of acute hospitals across NHS Scotland to focus on the safe delivery of care. Taking account of the changing risk considerations and sustained service pressures, the methodology was adapted 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 hospital managers. We will keep discussion with clinical staff to a minimum and reduce the time spent looking at care records.

From April 2023 our inspection methodology and reporting structure were updated to fully align to the Healthcare Improvement Scotland Quality Assurance Framework. Further information about the methodology for acute hospital safe delivery of care inspections can be found on our website.

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

Dumfries & Galloway Royal Infirmary is the main hospital in Dumfries. It serves the whole of Southwest Scotland. The hospital has 278 staffed beds and has a full range of healthcare specialties. NHS Dumfries & Galloway serves a population of over 148,000 but within a large geographical area of around 2,400 square miles.

About this inspection

We carried out an unannounced inspection to Dumfries & Galloway Royal Infirmary, NHS Dumfries & Galloway on Wednesday 11 and Thursday 12 June 2025 using our Safe Delivery of Care inspection methodology. We inspected the following areas:

- acute medical unit
- critical care unit
- emergency department
- paediatric ward
- ward B1
- ward B2
- ward B3
- ward C4
- ward C5
- ward C6
- ward D7
- ward D8, and
- ward D9.

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, and
- accessed patients' health records, monitoring reports, policies and procedures.

As part of our inspection, we also asked NHS Dumfries & Galloway 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 Tuesday 1 July 2025, we held a virtual discussion session with key members of NHS Dumfries & Galloway 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 Dumfries & Galloway and in particular all staff at Dumfries & Galloway Royal Infirmary for their assistance during our inspection.

A summary of our findings

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

Despite significant pressures on hospital capacity, inspectors observed multidisciplinary teams working together to deliver care.

Inspectors spoke with patients and families who were complimentary about the staff and care provided. Staff described visible and supportive managers and a clear reporting structure. The majority of wards were well led, calm and well organised. Senior charge nurses were easily identifiable, approachable and open to engage in conversation with inspectors.

NHS Dumfries & Galloway has effective systems in place to support student nurses and internationally recruited nurses.

Some staff explained to inspectors that while they would report an incident involving patient safety, such as a fall, on the electronic incident reporting system, they were unlikely to report staffing incidents such as poor skill mix or lack of available staff. Staff said they felt they did not have time to submit incident reports relating to staff shortages or skill mix.

Site wide hospital huddles we attended were multidisciplinary and supported staff to identify potential staffing risks. Senior nurses were visible throughout the inspection with staff and student nurses describing a positive and supportive culture in the hospital. Inspectors observed teams working hard to provide safe and effective care, which was reflected in the feedback from patients and their relatives.

Inspectors found mealtimes were well coordinated, patients were provided with hand hygiene prior to meals and those patients who required assistance were offered this in a timely manner.

Areas for improvement identified include ensuring staff are trained in fire evacuation, completion and updating of patient care documentation, staff compliance with standard infection control precautions such as hand hygiene and the sharing of learning following reporting of incidents.

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

This inspection resulted in 13 areas of good practice, two recommendations and 10 requirements.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed and the necessary improvements implemented.

A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

We expect NHS Dumfries & Galloway 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: http://www.healthcareimprovementscotland.scot

Areas of good practice

Domain 1	
1	Discharge without delay huddles were effective and proactive with teams working together to facilitate safe discharge from hospital (see page 14).

Domain 2	
2	Hospital wide and ward-based safety huddles were structured, inclusive and informative (see page 19).
3	Students reported positive practice and learning environments and support from staff within clinical areas (see page 19).

Domain 4.1	
4	Quality improvement initiatives in relation to the management of pain and treatment of patients with fractured neck of femurs (see page 24).
5	Patient mealtimes were well organised and coordinated. Patients were offered hand hygiene prior to mealtimes (see page 24).
6	All patient care equipment was clean and stored appropriately ready for use (see page 24).

Domain 4.3	
7	Collaborative working between all members of the multidisciplinary team (see page 29).
8	Effective and supportive wellbeing initiatives identified within wards with an open and supportive culture (see page 29).
9	Capacity team staffing provides innovative and flexible solution to continued system and staffing pressures, particularly to mitigate last minute staffing absence (see page 29).
10	Real-time staffing systems and processes appear well understood, inclusive and responsive to support patient safety and staff wellbeing via utilisation of informed professional judgement at various levels (see page 29).

Domain 6	
11	Patients and relatives speak highly of the care received (see page 31).
12	All observed interactions were kind, caring and respectful (see page 31).
13	Staff completed boards at patient bedsides to identify patient likes/dislikes to allow for quick identification if patient distressed (see page 31).

Recommendations

Domain 4.1	
1	NHS Dumfries & Galloway should consider improving staff awareness and use of the discharge lounge (see page 24).

Domain 4.3	
2	NHS Dumfries & Galloway should consider ways of providing appropriate support programme in place for nursing staff supporting internationally trained nurses (see page 29)

Requirements

Domain 1	
1	NHS Dumfries & Galloway must ensure all staff are provided with and complete the necessary paediatric and adult immediate life support training to safely carry out their roles (see page 14). This will support compliance with: The Code: professional standards of practice and behaviour for nurses' midwives and nursing associates (2018) and Health and Care (Staffing) (Scotland) Act (2019).
2	NHS Dumfries & Galloway must ensure effective and documented risk assessments and selection criteria are in place to support staff who are required to place patients within corridor beds (see page 14). This will support compliance with: Health and Social Care Standards (2017) criteria 1.23, 1.4, 2.11, 2.32, 4.14 and 5.22 and Quality Assurance Framework (2022) Indicator 2.1.
3	NHS Dumfries & Galloway must ensure all fire risk assessments are completed yearly and evacuation plans are updated to take into account the use of additional beds within clinical areas (see page 14). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

Domain 2	
4	NHS Dumfries & Galloway must improve feedback to staff on incidents raised through the incident reporting system and ensure learning from incidents is used to improve safety and outcomes for patients and staff (see page 19). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 3.1 and the National framework for reviewing and learning from adverse events in NHS Scotland (2025).

Domain 4.1	
5	NHS Dumfries & Galloway must ensure that all patient care documentation, including risk assessments, are accurately and consistently completed (see page 24). This will support compliance with: Quality Assurance System (2022) Criterion 4.1 and relevant codes of practice of regulated healthcare professions.
6	NHS Dumfries & Galloway must ensure staff have access to alcohol-based hand rub and comply with hand hygiene in accordance with current guidance (see page 24). This will support compliance with: National Infection Prevention and Control Manual (2023).
7	NHS Dumfries & Galloway must ensure staff comply with the safe management of sharps policies (see page 24). This will support compliance with: National Infection Prevention and Control Manual (2023).
8	NHS Dumfries & Galloway must ensure the safe storage of medication (see page 24). This will support compliance with: Professional guidance on the safe and secure handling of medicines (Royal Pharmaceutical Society) and relevant codes of practice of regulated healthcare professions.
9	NHS Dumfries & Galloway must ensure Adults with Incapacity section 47 certificates are completed fully and accurately (see page 24). This will support compliance with: Adults with Incapacity (Scotland) Act (2000) Health and Social Care Standards (2017) criteria 1.2, 1.3, 2.12, 4.1, 4.11 and 4.14 and relevant codes of practice of regulated healthcare professions.

Domain 4.3	
10	NHS Dumfries & Galloway must ensure all staff are able to access training required for their role (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

Despite increased capacity within the hospital, all areas inspected were calm and well organised. Staff we observed provided compassionate care. Staff who spoke with inspectors described Dumfries & Galloway Royal Infirmary as a good place to work.

At the time of this inspection NHS Dumfries & Galloway, like much of NHS Scotland, was experiencing significant pressures including increased hospital capacity and delayed discharges. During our inspection the hospital was operating at 105% bed occupancy. The British Medical Association and the Royal College of Emergency Medicine describe a safe bed occupancy level of less than 85%.

During onsite discussions NHS Dumfries & Galloway told us that it utilised contingency beds to create additional inpatient capacity and to support patient flow from the emergency department and acute medical unit.

When demand within the emergency department increases, patients can be placed in corridors whilst awaiting investigations, transfer, admission or discharge. There are four spaces within the corridor where patient beds can be placed. At each corridor space there is a bell on the wall to allow patients to obtain attention from a member of staff should they require it. Inspectors were told that a nurse is allocated to the corridor when patients are being cared for in the corridor area. This nurse will ensure all patient care needs are met including food, fluid and nutrition, pain relief and personal care. During the onsite inspection inspectors did not observe patients being cared for in the corridor of the emergency department.

We asked NHS Dumfries & Galloway for any reported staff or patient safety incidents from the previous six months. In the evidence provided there were no staff or patient safety incidents relating to the inappropriate placement of patients within the corridor in the emergency department.

Nursing staff in the emergency department explained to inspectors that there was no formal risk assessment or selection criteria for patients being placed into these additional non-standard care spaces. Staff explained that they use professional judgement when selecting patients who may be more suitable to be cared for in the corridor area. Staff told us patients at a high risk of falling, patients with cognitive impairment or any known or suspected infections, would not be cared for in the corridor. We discussed this with senior managers who explained that any decisions to place patients in corridors of the emergency department are made collaboratively with both nursing and medical staff. Senior managers also told us that a formalised risk assessment is being developed.

While Healthcare Improvement Scotland does not support the use of contingency beds and beds within non-standard care areas such as treatment rooms and corridors, we acknowledge that due to increased capacity and emergency admissions this may be required to ensure patients receive the care they require.

Where there is a requirement for the use of non-standard care areas NHS boards must ensure robust measures are in place to maintain patient dignity and respect. This includes, but is not limited to, conducting thorough risk assessments to ensure patient suitability and the safety of care delivery in these areas. A requirement has been given to support improvement in this area.

Within the acute medical unit inspectors were advised that patients may be placed in corridors to free up rooms to accommodate the flow of patients from the emergency department. However, like the emergency department staff told us there are no formal criteria or risk assessments in place to support this and it is based on professional judgement. Similarly to the emergency department, staff advised that those at increased risk of falls, disorientation, or increased harm would not be placed here.

The national target for accident and emergency waiting times means that 95% of patients should wait no longer than four hours from arrival at the emergency department before admission, discharge or transfer for other treatment. During the week of our onsite inspection, across NHS Scotland 71.8% of patients were seen within the four-hour target whilst 86.7% of patients were seen within four hours at Dumfries & Galloway Royal Infirmary. During the week of the onsite inspection, seven patients waited over eight hours, and no patients waited over 12 hours in Dumfries & Galloway Royal Infirmary's emergency department before being admitted, discharged or transferred to another area. While this is not within the four-hour target, fewer patients waited for extended periods in Dumfries & Galloway Royal Infirmary than many other emergency departments in Scotland during this time. Further information on emergency department attendances can be found here.

During our onsite inspection, although the emergency department was busy, the department was calm and well organised with care being coordinated safely. Staff were working hard to support patient safety.

During our onsite inspection inspectors did not observe any delays to patients being transferred from an ambulance into the emergency department. Emergency department staff told inspectors that on the occasions when patients remain in ambulances waiting for a bed space in the department, it is the responsibility of the Scottish Ambulance Service to monitor the patient and escalate any deterioration in the patient's condition. Emergency department staff told us that if a patient's condition deteriorates while waiting in the ambulance, Scottish Ambulance Service staff will alert the nurse in charge of the department and the patient will be brought into the resuscitation area. From the evidence submitted we observed there were no reported incidents relating to patients being required to wait within ambulances due to lack of capacity within the emergency department.

The Royal College of Paediatrics and Child Health standards 'Facing the Future: Standards for children in emergency care settings' documents that every emergency department treating children must have their qualified staff trained in infant and child basic life support, with one member of staff on duty at all times who has paediatric advanced life support (or equivalent) training. In evidence provided by NHS Dumfries & Galloway we were told that only 38.7% of nursing staff within the emergency department hold a current certificate in paediatric immediate life support. Currently there are no registered nursing staff within the emergency department with a current certificate in advanced paediatric life support. A requirement has been given to support improvement in this area.

There are no registered children's nurses or dual trained nurses employed within the emergency department at Dumfries & Galloway Royal Infirmary. In order to provide training and education for staff within the emergency department, senior managers told us they had placed a registered children's nurse from the children's ward in the emergency department on a rotational period to work alongside the staff. Staff reported this was beneficial as it allowed them to gain confidence and expand their knowledge and skills in relation to caring for children within the emergency department.

Additionally, there is a paediatrician based within the emergency department who also works with ScotSTAR (Scottish Specialist Transport & Retrieval). ScotSTAR is a national service for safe and effective transport and retrieval of critically ill children and adults throughout Scotland. We heard how ScotSTAR has been able to provide support, education and guidance to all staff, particularly the medical staff within the emergency department.

We spoke with senior managers about the process for the care of paediatric patients in an emergency situation within Dumfries & Galloway Royal Infirmary. We were told that medical and nursing staff from the children's ward can be contacted by the emergency department when a child attends the department in an emergency. We were told how staff from the children's ward would assist with the treatment of a child within the emergency department if contacted.

Senior managers explained that where appropriate, the patient will be transferred to the children's ward as soon as possible to ensure care within the correct care environment. Where a paediatric patient is required to be transferred to a specialist paediatric intensive care unit in another health board, the patient will be cared for within the intensive care unit in Dumfries & Galloway Royal Infirmary until the patient is transferred in collaboration with ScotSTAR. Senior managers told us that staff from the children's ward will go with the patient, to the intensive care unit, to ensure they receive specialist care from a registered children's nurse.

The handover checklist for a paediatric patient being transferred to another hospital includes patient details, including any specialist equipment or medication required. Information relating to the referring doctor from Dumfries & Galloway Royal Infirmary and receiving doctor where the patient is being transferred to will be included to

ensure continuity of care and clear points of communication. Additional information included consideration of the current staffing ratio and if transfer of the patient required an increase in staff due to specific needs.

Additionally, there is a flow chart for the transfer of paediatric patients. This is an aide memoire style to prompt staff to complete appropriate documentation such as the handover checklist and ensure communication with senior nursing and medical teams within both hospitals.

Scottish Government emergency signposting guidance seeks to ensure patients receive care in the most appropriate setting while helping to improve waiting times and reduce delays in emergency departments and acute admission units. Further information can be found at emergency department signposting/redirection.

NHS Dumfries & Galloway's redirection policy aims to reduce waiting times at the emergency department and ensure patients receive the right care in the right environment. The policy describes that patients should be assessed by a triage nurse using the Manchester Triage tool, and decisions made regarding appropriateness for redirection. If further guidance or support is required, the patient is then assessed by a member of the medical team. We observed in the redirection guidance that a defined group of patients can be identified and considered for signposting/redirection using specified criteria. These include any patients with a chronic illness or condition with no acute changes or acute deterioration in condition, dental conditions, conditions treatable by pharmacies such as hay fever and earache and requests for second opinions. Redirection guidance for Dumfries & Galloway Royal Infirmary includes, but is not exhaustive of, pharmacy first, dental services, NHS24 and mental wellbeing support.

Each staff member working within the triage area will have a competency triage booklet which lists a number of conditions treatable within the triage area. These include abdominal pain, chest infection, exacerbation of asthma and chest pain. This list is not exhaustive. Staff are assessed on their ability to triage patients appropriately depending on urgency of review, tests and investigations required, clear documentation of decision making and accurate documentation of findings. Staff are supported by advanced nurse practitioners and medical staff within this area.

When patients are redirected this is recorded on the electronic patient management system using specific codes. This allows regular audits to be carried out and identification of any adverse events relating to the redirection process. From evidence submitted, we did not observe any patient safety incident reports submitted as a result of patients being redirected from the emergency department.

During our onsite inspection Dumfries & Galloway Royal Infirmary had 32 delayed discharges. A delayed discharge occurs when a patient who is medically fit to be discharged from hospital cannot leave the hospital due to a lack of care, support or suitable accommodation such as a nursing home placement. Senior managers told us

all patients experiencing delayed discharge continue to receive all therapy required such as occupational therapy and physiotherapy.

NHS Dumfries & Galloway is part of a discharge without delay collaborative aimed at reducing delayed discharges from hospital. The discharge without delay collaborative aims to expedite discharges from acute hospital by ensuring patients are assessed by the frailty team and directed to the most appropriate service. These services include community rehabilitation services and home care support for patients who are medically fit for discharge or transfer to community hospitals. From evidence requested we saw the process aims to reduce length of stay and waiting times for packages of care for patients within hospital. This collaborative remains relatively new, therefore there is no data available to identify the impact this has had.

In addition to ward safety briefings, there are also multidisciplinary team huddles. These huddles are held on wards and take into account the current site position, any patients giving cause for concern, any planned discharges and anything that these patients may be waiting for such as review by a specialist service. This meeting allows for discussion of individual patient needs and highlights if patients are awaiting investigations, which can then be expedited by the capacity team to facilitate a safe discharge.

Whilst onsite inspectors had the opportunity to visit the acute medical unit. This is an admission and assessment ward which accepts patients from the emergency department as well as General Practitioner (GP) referrals. The acute medical unit has 32 inpatient beds and 10 assessment beds.

From evidence we were able to see the standard operating procedure for the triage of patients who attend the acute medical unit assessment area. This area is staffed by two registered nurses and one healthcare support worker and operates 9am – 9pm Monday to Friday. Patients can be brought in by the Scottish Ambulance Service. However, if there is any deterioration of patient condition during transfer patients will be redirected to the emergency department. We did not identify any incident reports where patients were redirected to the emergency department.

Inspectors visited one ward which cares for patients who require haematology, infectious diseases, gastroenterology and general medical care. These groups of patients often have complex care needs and require specific care practices, such as enhanced infection prevention and control precautions such as protective isolation for patients with a suppressed immune system within haematology.

Inspectors heard how mitigations were in place to protect immunocompromised patients, such as those being treated within a haematology pod. Each pod has a dedicated staff cohort who do not routinely care for other patients within the ward during the shift, unless in the event of an emergency. NHS Dumfries & Galloway confirmed that there had been no infection prevention and control outbreaks within this area.

NHS Dumfries & Galloway provided fire risk assessments for all clinical areas including the emergency department and areas with additional patients. In these, it was identified that the majority of staff had not undertaken an annual walkthrough fire evacuation drill. Additionally, the majority of the fire risk assessments had not been updated since 2022. NHS Scotland Firecode SHTM 86: 'Fire Risk Assessment' states that hospitals should have a yearly fire safety review. Additionally, fire risk assessments did not take into account specific actions required for the safe evacuation of patients from areas with additional beds, such as those in single rooms being used for double occupancy.

Senior managers told us that, in collaboration with the fire safety advisor, they are in the process of updating all risk assessments. In addition, plans are in place for staff to attend walk and talk drills. However, due to this a requirement has been given to support improvement in this area.

Area of good practice

Domain 1	
1	Discharge without delay huddles were effective and proactive with teams working together to facilitate safe discharge from hospital.

Requirements

Domain 1	
1	NHS Dumfries & Galloway must ensure all staff are provided with and complete the necessary paediatric and adult immediate life support training to safely carry out their roles.
2	NHS Dumfries & Galloway must ensure effective and documented risk assessments and selection criteria are in place to support staff who are required to place patients within corridor beds.
3	NHS Dumfries & Galloway must ensure all fire risk assessments are completed yearly and evacuation plans are updated to take into account the use of additional beds within clinical areas.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Staff reported feeling supported and listened to by senior managers. During the onsite inspection senior managers were visible within the hospital and present at hospital capacity huddles.

Hospital wide safety huddles we attended were held virtually throughout the day and attended by members of the multidisciplinary team including nursing, allied health professionals, hospital capacity team and facilities colleagues. Inspectors were told that the acute associate medical director also routinely attends the huddles.

The purpose of a safety huddle is to provide site situational awareness, understand patient flow and raise issues, such as patient safety concerns, review staffing and identify wards or areas at risk due to reduced staffing levels. We observed open and supportive conversations held regarding areas requiring additional support and early identification of potential staffing concerns that required escalating. Ward staff advised inspectors that should any safety or staffing concerns arise out with the allotted huddle times, they can escalate this, and this would be responded to promptly.

Inspectors were told that the emergency department and wards hold a safety huddle within each area. This process varies between area and may be held following shift changeover and prior to commencing a day or night shift or throughout the day or following ward rounds. These huddles are used to highlight any patient safety concerns such as those at higher risk of falls or those requiring assistance with mobility and mealtimes.

Within the children's ward inspectors heard how there are three huddles daily at 9am, 4pm and 8.30pm. Staff told inspectors that these are routinely attended by both medical and nursing staff. During the onsite inspection we had the opportunity to attend one of these huddles. The huddle was comprehensive and informative. All patients were discussed including their care needs and management plans.

Nursing staff in the emergency department explained to inspectors that they may hold more frequent huddles throughout the day in response to increased acuity in the department. Inspectors did not have the opportunity to observe this during our onsite inspection.

During our previous inspection in March 2023, we found that the double occupancy risk assessment was not applied consistently throughout the hospital and a requirement was given to support improvement in this area. During this onsite inspection we found all patients placed within double occupancy rooms had the double up criteria matrix completed and all patients were found to be appropriately placed.

Where a patient receiving end of life care has severe confusion or has a known or suspected transmissible infection, they will be unsuitable for the double accommodation rooms. This list is not exhaustive and other aspects of care needs are considered. Staff reported that capacity teams are receptive to feedback if a patient is unsuitable to being moved into a double room and work with ward staff to identify alternative patients. Within the double up criteria matrix document there is also space to acknowledge and record that there has been a discussion with the patient to explain the process, and this is recorded in the patient's clinical notes. On one ward, inspectors spoke with a patient who had initially agreed to be cared for in a double accommodation room. However, once moved into the room they did not feel comfortable. The patient also explained that staff were able to return them to single room occupancy.

We observed all patients within the double occupancy rooms had access to a call system, and that wall mounted oxygen and electrical points were available. Ensuite facilities were available in all rooms and portable privacy screens were available if required. Nursing staff explained that one patient would be moved out to corridors to allow additional privacy during ward rounds or in the event of an emergency. We did not observe patients being moved out of double occupancy rooms to allow for additional privacy during our onsite inspection as inspectors were not present during ward rounds for these patients.

During discussions with nursing staff we heard that potential challenges in the use of double occupancy rooms can be encountered in relation to patient dignity and respect such as the requirement for private conversations between patients and medical professionals.

Additionally, staff advised it can be difficult to ensure visibility of patients within double occupancy rooms. Within one ward, staff told us that although it has never happened, they had concerns that it may be difficult for staff to respond to emergency situations within double occupancy rooms. This may be due to access and availability of space within the rooms due to patient belongings and equipment. Delays may also occur in relation to removing the additional patient from the room. From incident reports we did not see any incidents relating to the care of patients within double occupancy rooms. In order to mitigate these concerns senior charge nurses told inspectors that staff are reminded to ensure rooms are tidy with clear access routes, particularly in double occupancy rooms in the event of emergencies. Additionally, staff are encouraged to escalate any concerns with patient observations or changes in patient's condition at the earliest opportunity in order to mitigate unexpected deterioration. During the onsite inspection we observed the application of the risk assessment developed by the board for double occupancy in place. This risk assessment mitigated potential risks associated with the use of double occupancy rooms. Many of the patients we spoke with in double occupancy rooms told us they preferred having the company as opposed to being in a room alone.

Inspectors had the opportunity to speak with student nurses whilst in clinical areas. All student nurses described a friendly and supportive culture within Dumfries & Galloway Royal Infirmary, with many student nurses hopeful of securing nursing posts in the hospital.

We spoke with medical staff at NHS Dumfries & Galloway who described feeling listened to when raising concerns and a feeling of being well supported by senior colleagues during all shift patterns. Doctors also spoke highly of the support received from other specialities within the hospital.

We observed that medical notes reviewed were well written and patients had clear management plans in place. Additionally, senior medical staff spoke positively about the organisation's culture, teamwork and leadership. We were told that many of the resident doctors had actively chosen to return to Dumfries & Galloway Royal Infirmary for further specialist training following their foundation years describing a positive

foundation year experience as a key factor in that decision. Resident doctors are qualified doctors who are undertaking further clinical training and work under the supervision of a senior doctor.

From evidence submitted in relation to safety incidents we were able to see that learning is recorded on the electronic system following the investigation of an incident. However, when inspectors spoke with staff during the onsite inspection, staff said they often do not receive feedback in relation to incident reports submitted. Senior managers from NHS Dumfries & Galloway advised that staff could select an option within the system when reporting an incident, to state they wish to receive feedback. However, they agreed that due to the introduction of the new system many staff may not be aware of this and learning may be required in relation to this. Due to this a requirement has been given to support improvement in the delivery of feedback from incidents.

From evidence submitted we saw the highest three categories of incidents reported were slips, trips and falls, pressure ulcers and medication incidents. NHS Dumfries & Galloway uses an electronic safety reporting system to report incidents, near misses or emerging concerns in real-time. In order to support robust governance processes in relation to this, a review of risk data such as incident reports, complaints and audit findings are discussed at clinical governance meetings and the risk oversight group. This information is then shared with clinical teams through the clinical nurse managers who attend the meeting and disseminate the information to senior charge nurses.

From incident reports received we saw a high number of falls reported throughout the hospital where the use of bedrails was documented in patients with a known cognitive impairment. We raised this with senior managers who explained there is currently a review being carried out with regards to falls related documentation, including falls risk assessments and bed rail assessments as they had identified that there were several documents and assessments relating to the topic of falls. There is a plan to centralise these risk assessments into one booklet with the aim of improving compliance with completion of these risk assessments. As part of evidence requested, NHS Dumfries & Galloway provided us with their bedrail assessment where we can see the use of bedrails for patients with a cognitive impairment is not contraindicated. However other mitigations may be considered such as a variable height bed, anticipating care needs such as toileting and food fluid and nutrition and ensuring the inclusion of carers or family members in the creation of the falls care plan. During the inspection inspectors observed these mitigations in place with patients being moved to bedrooms with more visibility and increased frequency of care rounding.

We were made aware of improvement work being carried out to reduce patient falls within one medicine for the elderly ward. Initial learning from falls within this area found that patients were not encouraged to mobilise and on many occasions patients were frustrated due to lack of activities and poor understanding of their environment. Additionally, it was found that some staff required further training on the safe management of patients with cognitive impairments such as dementia. Changes were

implemented to encourage safe mobilisation such as encouraging patients to be out of bed, collaboration with allied health professionals and medical colleagues to promote safe mobilisation. Currently there is no activities coordinator within the ward, however this is being explored as a possible introduction working in collaboration with occupational therapy.

NHS Dumfries & Galloway worked in collaboration with the Scottish Patient Safety Programme to create a falls reduction storyboard. The storyboard details the changes being tested as mentioned above, implementation of these and enablers and challenges to the changes such as limitations on staffing and increasing complexity of patients. The storyboard provides a visual representation of the work having been carried out within the ward.

Introduction of 'This is Me' cards in each patient's rooms also helped identify care needs, tell staff about the patient and highlight how staff can help if the patient becomes distressed. Additionally, 'I can' cards were placed at patient bedsides which highlight mobility needs. Staff also found the introduction of red mobility frames and increased opportunities to carry out meaningful activities all contributed to the reduction in falls rates.

Within one clinical area inspectors were told about monthly morbidity and mortality meetings. These meetings are attended by both nursing staff and medical staff. Patient care can be discussed and any learning can be identified and shared. Staff reported that these meetings are incredibly beneficial as it allows a debrief where all aspects of the patient's care is discussed. Additionally, any improvements are also discussed should the same situation arise in the future. These meetings are focused on providing support to staff, ensuring learning and improving future outcomes for patients.

Within one area inspectors were told of a shared Microsoft Teams channel which can be accessed by staff within that clinical area. This channel is used as a method of sharing learning from adverse events and incidents. Staff spoke positively about this as it allowed them to close the loop on any incidents that they may have reported or adverse events that they may have been involved with.

Inspectors were told about weekly senior charge nurse meetings which allow ward managers to meet and share learning from incidents and discuss any potential challenges they are facing. Additionally, staff told us this gives them an opportunity to receive support and guidance from colleagues. Staff reported they feel like they can talk openly and candidly in these meetings.

During the onsite inspection inspectors had the opportunity to talk to staff from domestic services. Domestic staff told inspectors that they have enough time to complete allocated jobs and can obtain support from supervisors should this be needed. Additionally, domestic staff stated that they have an adequate supply of cleaning products and equipment to allow them to carry out their roles.

Areas of good practice

Domain 2	
2	Hospital wide and ward-based safety huddles were structured, inclusive and informative.
3	Students reported positive practice and learning environments and support from staff within clinical areas.

Requirement

Domain 2	
4	NHS Dumfries & Galloway must improve feedback to staff on incidents raised through the incident reporting system and ensure learning from incidents is used to improve safety and outcomes for patients and staff.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

We observed good teamwork in all areas inspected with ward managers visible in the majority of areas. Patient bedrooms were clean and tidy. All patients within ward areas had access to call bells which were answered promptly.

Inspectors visited the orthopaedic ward which had implemented improvements in relation to the care of older patients and the specific needs of older people within orthopaedics. Inspectors were able to see evidence of improvement work such as a protocol for management of patients with a fractured neck of femur. This protocol assists with the selection of appropriate pain management for patients pre and post operatively.

Inspectors also heard how the pain specialist nurse within the orthopaedic ward was able to support the delivery of pain relief to patients who have experienced a fractured neck of femur. Inspectors were told how this is a task normally carried out by the anaesthetic team. However, following training this can be carried out by pain specialist nurses. Staff reported that this has made a positive difference for patients and staff, as staff do not need to await attendance of medical staff to review patients and prescribe medications. Pain specialist nurses can review patients in a timely manner, therefore alleviating pressure on medical staff and ensuring patients receive adequate pain relief in a timely manner.

Additionally, the pain specialist nurse has worked with medical and nursing staff in the ward to develop new analgesia regimes to prevent overuse of patient controlled analgesia pumps. The NHS Dumfries & Galloway Pre & Postoperative Pain Management Guidelines provides staff with guidance on the management of pain in patients with fractured neck of femur, assessment of the patient's cognitive state, monitoring of patients' bowel movements and conversions of opioid analgesics.

Additional information is provided on the de-escalation of opioids. This supports a whole patient approach to the treatment of pain.

The orthopaedic department has introduced an orthogeriatric assessment which assesses aspects of patient care needs such as falls history, bone health review and cognitive state. Additionally, the senior charge nurse and team within the orthopaedic ward are in the process of developing an education pack for patients admitted to hospital with a fractured neck of femur. This ensures teams within the hospital will have quick access to resources on the management of these patients.

Senior managers told us about work initially carried out within the orthopaedic ward on recognising the signs of a deteriorating patient and their plans to extend this throughout the hospital. This includes the introduction of a mandatory electronic learning module on the deteriorating patient and introduction of a link nurse for the deteriorating patient. During the virtual discussion we asked if these changes had led to a reduction in emergency calls in response to patients whose condition had deteriorated. We were told that each emergency call is reviewed weekly and have seen a slight increase in peri-arrest calls as patients who have deteriorated are being highlighted more effectively. A peri-arrest call alerts the resuscitation team in a hospital to a patient who has deteriorated. Senior nursing colleagues also meet fortnightly with the resuscitation officer to look at emergency calls and any learning that may be shared.

In addition to this nursing staff carry out audits and collect data to submit to the Excellence in Care programme. This data highlights where procedure has been followed to repeat observations and escalate concerns and situations where opportunities may have been missed. Data from these audits are shared with staff within the ward at safety briefings and displayed to ensure everyone is aware of results and areas for improvement and shared learning.

The orthopaedic consultant service model has been reviewed and updated. Previously one consultant was responsible for patients who required trauma care, carrying out ward rounds, trauma rounds and for orthopaedic trauma operative procedures. However, there is now a second consultant with the responsibility of carrying out operative procedures. Staff feedback that this has meant ward rounds can be more focused and deteriorating patients are reviewed in a more timely manner.

Inspectors had the opportunity to review a variety of patient care documentation. Within the majority of ward areas the patient care documentation was completed to a high standard with risk assessments detailed, completed in expected time frames and updated as indicated, for example a falls risk assessment updated following a fall.

However, within the emergency department, inspectors found poor compliance with completion of nursing assessments. Whilst on site we were able to see the emergency care centre nursing assessment notes and initial National Early Warning Score 2 (NEWS2) document. This document is a four page document that includes a number of risk assessments within it including nutritional assessment, falls risk assessment and

swallow screening assessment NEWS2 charts are used to record a patient's physiological parameters such as pulse and blood pressure and will alert staff if a patient is at risk of deterioration. Inspectors observed poor compliance with the completion of this document, with some staff advising they may not complete all risk assessments depending on their clinical judgement and would document reasons why they have not completed this. However, inspectors observed that where nursing staff were not completing risk assessments, they were not documenting their clinical judgement rationale for not doing so. Risk assessments are important as they aide staff to identify patient care needs and identify any risks, adaptions or additional patient support needs. To support improvement in this area a requirement has been given.

Inspectors observed in one ward that patient moving and handling assessments were not being updated post operatively which failed to highlight any change in mobility requirements. This was raised with the senior charge nurse at the time of feedback who advised they would have these reviewed and updated and highlight to staff the importance of updating risk assessments. A requirement has been given to support improvement in this area.

Inspectors observed in ward areas good overall completion of NEWS2 charts where these were available to review. However, on some occasions repeat observations had not been completed in the correct timescale. This was raised with nursing staff at time of inspection.

We saw in evidence provided the adult observation chart in use within Dumfries & Galloway Royal Infirmary. This is a four page document with guidance for staff on carrying out observations, as well as an area to document any escalations of NEWS2 or if there are any clinical concerns with a patient. This part is called 'What you did and why.' Staff can document the NEWS2 total or clinical concern, who the concern was discussed with and what action was taken. In one example inspectors observed this had been completed well following a patient being identified as having an elevated NEWS2 score with a clear plan of care.

During our onsite inspection we had the opportunity to observe a number of mealtimes. In most areas these were well organised, and the meals were distributed in a timely manner. All staff members were observed to be assisting in distributing meals and patients received assistance when required. Where a patient declined assistance a member of staff would check back with this patient and aid if required. This showed a level of support to enable the patient to attempt a meal but recognition of not allowing the mealtime to fully pass without the patient being aided. Inspectors observed that patient bed tables were cleared in preparation for meals being distributed and staff were aware of patients who required assistance and those who had specialised dietary requirements. Within the majority of wards, staff were observed facilitating patients to carry out hand hygiene prior to mealtimes. Patients were provided with hand wipes and encouraged to carry out hand hygiene prior to meals.

Hand hygiene is an important part of standard infection control precautions to minimise the risk of infection. Other standard infection prevention and control precautions include patient placement, the use of personal protective equipment (such as gloves and aprons), management of the care environment, safe management of blood and fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

Within the children's ward inspectors found posters on display to encourage patients and parents to encourage staff to carry out hand hygiene if they had not seen this being done.

Hand hygiene involves '5 moments' when hand hygiene should be performed. These are prior to touching a patient, prior to performing a procedure, after a procedure or body fluid exposure risk, after touching a patient or after touching a patient's surroundings. Inspectors observed that all staff groups in the majority of clinical areas performed hand hygiene appropriately. However, in two areas inspectors observed poor compliance with hand hygiene guidance across all staff groups. This may have been due to the availability of alcohol-based hand rub dispensers in the corridors within one of the areas.

We asked senior managers for further information in relation to the removal of alcohol-based hand rub dispensers from one clinical area. We were told there was no formal risk assessment completed in relation to the removal of the dispensers, following our onsite inspection and feedback there are plans in place to have the dispensers repositioned. The dispensers will be repositioned within the emergency department at convenient points of use for staff.

In our previous Safe Delivery of Care inspection of Dumfries & Galloway Royal Infirmary in March 2023 we also observed poor compliance with hand hygiene opportunities. While we recognise the improvements in staff compliance in hand hygiene, a new requirement has been given to support improvement.

During our previous inspection in March 2023 we observed poor compliance with safe storage of sharps and a requirement was given to support improvement in this area. During this inspection inspectors observed several sharps storage containers overfilled, unlabelled and with temporary closure not in place. The use of the temporary closure prevents needles or other sharp objects protruding from the boxes or falling out of the container if it is dropped. Due to this a new requirement has been given to support further improvement in this area.

Transmission-based precautions are additional infection control precautions that should be used by staff when caring for a patient with a known or suspected infection. We observed several areas where these precautions were in use. Clear signage was in place and staff were observed correctly using and disposing of personal protective equipment in these areas.

Personal protective equipment includes items such as disposable aprons and gloves. During our inspection we observed that staff used this appropriately and that there

were sufficient supplies of personal protective equipment available throughout the clinical areas inspected. Inspectors also observed posters throughout wards explaining how to correctly use personal protective equipment.

During the inspection inspectors observed that chlorine-based cleaning products were stored securely in line with The Control of Substances Hazardous to Health (COSHH) Regulations 2002 which stipulate that these products must be kept in a secure area such as a locked cupboard. Where chlorine releasing agents are not stored securely this may result in a risk that it may be accessed by patients or members of the public. We observed chlorine-based cleaning products stored in swipe access domestic storerooms and locked cupboards within dirty utilities which were situated in main corridors of the hospital.

Within all areas checked all patient care equipment was clean and stored appropriately. All equipment was stored safely, ensuring corridors were unobstructed. All fire escape routes and exits were clear, well signposted and unobstructed.

Inspectors spoke with staff regarding the flushing of water outlets within the hospital. Water flushing records are carried out and maintained electronically, staff were able to show evidence of this being carried out and inspectors were able to identify complete records.

We observed all preparation and medicine storage rooms had restricted access using a swipe card access and all medication storage cupboards within were locked. Within all wards visited there were numerous drug trolleys as the wards are split into ‘pods’ or teams. Inspectors observed in the majority of wards that the medicine trolleys remained in the corridors during and following completion of a medication round. Whilst the medicine trolleys were locked and medication stored securely within, the trolleys were not secured to a fixed surface This is not in line with current guidance from the Royal Pharmaceutical Society which states medicine trolleys should be secured at an anchor point (such as pointing at which trolleys can be secured to the floor or wall) when not in use. Alternatively, medicine trolleys may be stored securely in a locked room when not in use if access to the room is restricted to authorised persons. Due to this a requirement has been given to support improvement in this area.

Inspectors observed Adults with Incapacity Section 47 Certificates completed for a number of patients throughout the hospital. These are legal documents which assist patients, their families and staff to make decisions regarding a patient’s care and treatment when the patient is unable to make the decision independently. We observed that while the majority of these were well completed, some of the certificates inspectors were able to review were incomplete, missing some patient information and no information documented regarding medical interventions or procedures. Inspectors raised this with the nurse in charge and were told that medical staff would review these immediately. A requirement has been given to support improvement in this area.

Whilst onsite inspectors visited the discharge lounge. We initially found it challenging to locate the discharge lounge as signage and staff awareness of location appeared poor. The discharge lounge is within a previous treatment room, adjacent to one of the wards and is staffed by one healthcare support worker. Inspectors heard how patients who are transferred to the discharge lounge are those who are deemed fit to go home or return to their care facility and are relatively low acuity. Patients are able to access toilet facilities in the adjacent ward. Within the discharge lounge the healthcare support worker is responsible for arranging and coordinating patient transport and collection of medications from pharmacy.

Within the emergency department staff told inspectors they don't feel the discharge lounge is utilised optimally to ensure ongoing flow of patients from the emergency department through the hospital. During the hospital huddles staff were reminded of the availability of the discharge lounge and staff were encouraged to use this. However, due to onsite findings and discussions with staff a recommendation has been given relating to this.

Areas of good practice

Domain 4.1	
4	Quality improvement initiatives in relation to the management of pain and treatment of patients with fractured neck of femurs.
5	Patient mealtimes were well organised and coordinated. Patients were offered hand hygiene prior to mealtimes.
6	All patient care equipment was clean and stored appropriately ready for use.

Recommendation

Domain 4.1	
1	NHS Dumfries & Galloway should consider improving staff awareness and use of the discharge lounge.

Requirements

Domain 4.1	
5	NHS Dumfries & Galloway must ensure that all patient care documentation, including risk assessments, are accurately and consistently completed.
6	NHS Dumfries & Galloway must ensure staff have access to alcohol-based hand rub and comply with hand hygiene in accordance with current guidance.
7	NHS Dumfries & Galloway must ensure staff comply with safe management of sharps policies.
8	NHS Dumfries & Galloway must ensure the safe storage of medication.
9	NHS Dumfries & Galloway must ensure Adults with Incapacity section 47 certificates are completed fully and accurately.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Staff we spoke with described having good senior leadership support in place and that senior managers were accessible. Staff reported that the leadership was supportive and responsive when staff were raising concerns.

Site safety huddles we attended were inclusive of all departments and gave a whole site overview in real-time. Staff we spoke with described having senior leadership support in place and staff felt confident to escalate any concerns such as staffing shortages.

NHS Scotland continues to experience significant workforce pressures compounded by staffing vacancies, recruitment challenges and staff absence. From evidence received during the inspection we can see that the vacancy rate for band 5 registered nurses is 10.3% and the vacancy rate for band 3 healthcare support workers is 13.1%. The NHS board reports that it is over establishment by 2.7% for band 6 nurses. We consider high vacancy levels as greater than 10%. During the inspection vacancy rates within other professions were not highlighted as an area of concern by NHS Dumfries & Galloway senior managers.

During the onsite inspection senior charge nurses and charge nurses took time to speak openly and honestly with inspectors. The majority of senior charge nurses described having appropriate time to lead and advised they were working with their staff to aid with personal and professional development. On some occasions senior charge nurses described having to change duties from supervisory management day to taking a clinical caseload due to short term sickness.

Within one area inspected the senior charge nurse described challenges with completing staff appraisals and return to work meetings. To support the completion of these the area has moved to a paper-based system for appraisals as opposed to electronic to identify if this supported the increased completion of staff appraisals. This process has recently been introduced, therefore any improvements in completion rates are not yet available. Additionally, inspectors were told lead nurses are supporting senior charge nurses in order to carry out return to work meetings alongside human resources department. Within other ward areas visited inspectors were told that all appraisals were up to date with the majority of staff having completed their review for the year.

Inspectors were able to identify members of the multidisciplinary team working collaboratively within all wards visited. Allied health professional staff such as physiotherapists and occupational therapists were visible within all wards inspected and were willing and open to speaking with inspectors. Ward nursing staff did not highlight any concerns with any shortages of allied health professionals, and they agreed they were able to have patients assessed and reviewed in a timely manner. Patients also spoke highly of contact with allied health professionals.

Staff had open discussions with inspectors in relation to their wellbeing and support available, particularly following an adverse event or a challenging shift. Staff described an environment of care and that their wellbeing on a shift is valued. Staff within one ward were able to discuss the support of colleagues and staff following events where they would use the hot and cold debrief method as a team. Staff reported that they are encouraged to reflect and discuss anything that concerns them. This was highlighted as an area of good practice.

In one ward visited, staff reported wellbeing activities such as holding a walking group with regular meet ups for walks with pets and family meet ups if staff wished to participate. These were reported to be positive activities as it allowed staff to meet up in a more relaxed setting as due to the large number of staff on the ward they may not see colleagues for prolonged periods due to shift patterns. These groups were open to both substantive staff and student nurses. Additionally, pre-registration student nurses described a highly supportive environment for learning and development. Furthermore, pre-registration student nurses reported feeling able to approach any member of staff for help and advice.

On each ward there was an awareness of the challenges of managing large groups of staff but in general there was good support and team working across the board.

Within one ward the senior charge nurse had developed a leadership programme for the band 3 healthcare support workers. This aimed to aide in the development of skills of planning patient care, patient management and task management. This programme is relatively new, however there are plans to assess the efficacy and introduce to other areas within the hospital.

Staff within the ward would take the opportunity to undertake training if available. In addition to this, in house training by clinical nurse specialists is often provided, such as tracheostomy care and pain management training. This can be provided within the ward to allow for as many staff as possible to have this training.

Inspectors discussed mandatory training rates, although inspectors did not see evidence of completion rates, senior charge nurses reported these to be high, however, noted that any supplementary training had to be undertaken in personal time and no pay or time back would be provided.

Within the critical care unit inspectors were told of an induction pack for new employees who are routinely working within a supernumerary position for a 4 week period initially, depending on critical care experience. This pack explains the type of patients typically cared for within the critical care unit such as those requiring respiratory and/or organ support. A procedures and training checklist is provided for staff to tick and sign off completion of training in topics such as the administration of high flow nasal oxygen therapy and the interpretation of an electrocardiogram (ECG). An ECG is a tracing of the heart taken to identify any possible abnormalities with the heart rhythm. Additionally, the pack includes scenarios in which staff are required to discuss and document the signs and how to recognise abnormal heart rhythms

through the ECG such as atrial fibrillation and ventricular tachycardia. Other competencies assessed are the awareness of the administration of medicines through different routes such as intravenous and subcutaneous routes.

NHS Dumfries & Galloway board papers highlighted challenges with staff being released to attend training courses. Whilst on inspection the feedback was similar with staff highlighting that focus is placed on mandatory learning and any additional training can often be cancelled or staff are not released to attend. Additionally, we heard how staff often are expected to complete mandatory electronic learning modules at home on their own time. Staff told inspectors that attempts are often made to give time back for this, however due to challenges with staffing and acuity in the wards this is not always possible. Under the requirements of the Health and Care (Staffing) (Scotland) Act 2019 there is a duty to release staff for training (Duty 12II). A requirement has been given to support improvement in this area.

During the onsite inspection we had the opportunity to meet with the capacity team. This team is onsite at all times, there are two band 7 nurses who work day shift and one band 7 at night. The function of the capacity team is to assess bed requirements, assist with discharge planning and ensure safety of patients and staff. During the day staff will contact the capacity team to discuss patient movements and discharges and where appropriate investigations may be expedited to facilitate patient discharge. Overnight the capacity team are the first point of contact for any issues within the hospital, including staffing and patient safety.

In addition to the capacity staff, a relief team of staff employed on permanent contracts who report to the capacity office at the start of their shift and are advised which clinical area they are required to work in. This relief team currently comprises of two registered nurses and four healthcare support workers, however we were told that following recruitment, this has been increased. Following interviews there are an additional 10 registered nurses who have been employed to be part of the capacity team on a permanent basis.

The staff on the relief team have a varied range of experience from working across numerous specialisms and clinical areas. This coverage allows for any areas highlighted as unsafe to start to become safe to start through deployment from the relief team and allow for shifts to be allocated to the nurse bank where the relief team is unable to cover.

Capacity team management staff advised that the data of where staff are being sent is monitored in relation to relief team usage and discussed at nurse scrutiny meetings. The data assists with workforce planning and highlights clinical areas where additional staffing is required long term.

Following feedback from the clinical teams and relief teams to senior managers there is a plan to provide newly qualified nurses with rotational blocks within a variety of clinical areas. This will allow for a broad range of experience of specialisms and give good experience to newly qualified nurses.

As discussed earlier in the report, during the onsite inspection we attended the site safety and capacity huddles during which staffing was discussed. From information shared during the hospital capacity huddle we were able to see there were no areas highlighted as unsafe to start prior to the huddle, however due to short term sick calls several areas highlighted shortfalls at the end of the huddle. We discussed this with senior managers at the staffing discussion who advised that the absences had not been declared prior to the huddles due to late sickness calls. Senior managers advised us that the use of safe care remains relatively new and they are continuing to support staff to complete it as accurately as possible.

Active discussions were held in order to provide assistance to the wards which were unsafe to start for the morning shift. Staff were offered from a number of areas and all areas were deemed safe to start. During discussions with the capacity team they advised that following deployment of staff and bank shifts being covered, all areas were now safe for the afternoon and night shift.

From evidence we observed mitigations being implemented to ensure wards were safe. Additional evidence, including the staffing documentation from NHS Dumfries & Galloway, show reasons and mitigations to support staffing decisions such as reasons for poor skill mix due to sickness absence and details deployment of staff between areas detailing who is required to move from where. Not having the appropriate staffing level or skill mix can have an adverse impact on the safe delivery of care, particularly if staff are unfamiliar with the NHS board, or the clinical area and do not have the necessary skills, knowledge and experience. This was highlighted as an area of good practice relating to real-time staffing. Real-time staffing systems and processes appear well understood, inclusive and responsive to support patient safety and staff wellbeing via utilisation of informed professional judgement at various levels.

Inspectors were told that a number of internationally trained nurses had been recruited into the hospital in response to a high vacancy rate. We asked NHS Dumfries & Galloway for evidence about how internationally trained nurses are supported and were provided with information on the extensive support available for these nurses. We were told that each internationally recruited nurse has a pastoral buddy who links in and collects them from the airport or train station and helps to induct them into the local area. Assistance is provided to set up bank accounts and are included in online groups for peer support and socialisation.

In relation to training for internationally recruited nurses, there is a 12-week model which includes two Objective Structured Clinical Exam training days, as well as shadow working days and self-practice and transitional sessions. An Objective Structured Clinical Examination (OSCE) is a common method of assessing clinical competence in medical education, it assesses performance in a simulated clinical environment. Internationally recruited nurses complete this training in order to pass the Nursing and Midwifery Council OSCE in order to obtain registration with the Nursing and Midwifery Council.

We asked NHS Dumfries & Galloway what support, if any, is in place to support the nursing staff who are mentoring internationally trained nurses. NHS Dumfries & Galloway did not provide evidence of formal support available, therefore a recommendation has been given to support improvement in this area.

Areas of good practice

Domain 4.3	
7	Collaborative working between all members of the multidisciplinary team.
8	Effective and supportive wellbeing initiatives identified within wards with an open and supportive culture.
9	Capacity team staffing provides innovative and flexible solution to continued system and staffing pressures, particularly to mitigate last minute staffing absence.
10	Real-time staffing systems and processes appear well understood, inclusive and responsive to support patient safety and staff wellbeing via utilisation of informed professional judgement at various levels.

Recommendation

Domain 4.3	
2	NHS Dumfries & Galloway should consider ways of providing appropriate support programme in place for nursing staff supporting internationally trained nurses.

Requirement

Domain 4.3	
10	NHS Dumfries & Galloway must ensure all staff are able to access training required for their role.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

Inspectors observed staff working hard providing compassionate and person-centred care. Patients we spoke with described attentive, supportive and caring staff and acknowledged how busy the staff were.

All patients appeared well cared for, they were appropriately dressed at their bedside or in bed, with nurse call bells to hand and access to fluids and personal belongings. However, within one ward patients and relatives said they felt that care can be rushed at times due to the high activity within the ward, however no adverse event or impact on care was reported.

Patients in the majority of wards described being very well cared for. Patients reported receiving prompt assistance when required and described the nursing care and wider

multidisciplinary team care as exceptional. This was fed back to the charge nurses at the time of the inspection. Additionally, patients reported timely access to medications such as pain relief and time critical medicines.

Inspectors visited the palliative care ward. All staff were found to be extremely caring and compassionate in providing care to patients and their families. The ward was calm and welcoming.

All single rooms within Dumfries & Galloway Royal Infirmary have large, accessible ensuite shower rooms. The ensuites are spacious enough to allow for staff to assist patients with showering, while being able to utilise moving and handling equipment within the room also.

As described earlier in this report, within the acute medical unit and emergency department inspectors were advised that patients may be placed in corridors to accommodate the flow of patients from the emergency department. We have given a requirement for improvement in this area earlier in the report. We asked senior managers how patients being cared for within the corridors access toilets and shower facilities if required. Senior managers told us patients can access a shared toilet and shower, however patients are rarely cared for in the corridors for a prolonged period of time. We were told that where a patient requires assistance with personal care or accessing the toilet, they would be moved to one of the bays to ensure patient privacy and dignity. Senior managers also told us there are tables are available for patients who are being cared for within the corridors to ensure patient comfort when eating and drinking.

Inspectors were told about a frailty multidisciplinary team, who are based within the acute medical unit to assist the centralised planning and safe discharge from the unit without the need for these patients to be sent to other wards. The patients' care and discharge are facilitated through this team, including the need for physiotherapy and any additional support whilst in hospital. Staff discussed the benefits of this with inspectors, highlighting that it takes some of the responsibility of this care planning from acute nursing staff, thus, making the process more streamlined due to their knowledge.

Within the emergency department inspectors discussed patient care needs with staff. They advised that there is a task board outside each room which highlights any specific care needs that patient may have. These needs include personal care needs, pressure area care, fluids and time critical medication. Inspectors were able to see these charts in use and described good compliance with administration of time critical medicines.

In one ward inspectors found patient boards at bedsides were a condensed version of the 'Getting to Know Me' document. 'Getting to Know Me' is a simple tool that can be offered to anyone within hospital but is particularly useful for those with a cognitive impairment. The document allows us to get to know the person, understand who and what is important to them and what their likes and dislikes are. Inspectors found these boards were completed to a high standard making it easy for staff to identify likes,

dislikes and highlight any aids or assistance needed when carrying out activities of living.

Staff reported they find these boards useful as they can identify at a glance what may assist when a patient becomes distressed and may therefore help deescalate situations. Additionally, there are whiteboard markers left in the rooms and families and carers are encouraged to contribute to completing the boards. Additionally, inspectors were told by some relatives that it was reassuring that staff knew what was important for their loved one.

Within the children's ward inspectors found that patients are encouraged to be involved in decisions about their care. Parents told inspectors that staff are caring and compassionate and listen to concerns raised. There is also a play leader within the children's ward who provides children with activities whilst in hospital. Both patients and parents spoke highly of their impact.

During the previous Safe Delivery of Care inspection in March 2023 inspectors raised concerns about the use of a closed-circuit television camera (CCTV) situated in a patient interview room within the emergency department. During this inspection the CCTV camera was found to have been removed and no longer in use.

Areas of good practice

Domain 6	
11	Patients and relatives speak highly of the care received.
12	All observed interactions were kind, caring and respectful.
13	Staff completed boards at patient bedsides to identify patient likes/dislikes to allow for quick identification if patient distressed.

Appendix 1 - List of national guidance

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

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Ageing and frailty standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 2024)
- Delivering Together for a Stronger Nursing & Midwifery Workforce (Scottish Government, March 2025)
- Fire Scotland Act (Acts of the Scottish Parliament, 2005)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, October 2014)
- Generic Medical Record Keeping Standards (Royal College of Physicians, November 2009)
- Health and Care (Staffing) (Scotland) Act (Acts of the Scottish Parliament, 2019)
- Health and Social Care Standards (Scottish Government, June 2017)
- Infection prevention and control standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, May 2022)
- National Infection Prevention and Control Manual (NHS National Services Scotland, January 2024)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Healthcare Improvement Scotland, November 2022)
- Prevention and Management of Pressure Ulcers - Standards (Healthcare Improvement Scotland, October 2020)
- Professional Guidance on the Administration of Medicines in Healthcare Settings (Royal Pharmaceutical Society and Royal College of Nursing, January 2019)
- The quality assurance system and framework – Healthcare Improvement Scotland (Healthcare Improvement Scotland, September 2022)
- Staff governance COVID-19 guidance for staff and managers (NHS Scotland, August 2023)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)
- A national framework for reviewing and learning from adverse events in NHS Scotland (Healthcare Improvement Scotland, February 2025)

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