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Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Western Isles Hospital

NHS Western Isles

3 – 4 September 2024

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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

Western Isles Hospital is a small, rural general hospital located in Stornoway. It is the largest of the three hospital services within NHS Western Isles, with a total capacity of 98 beds (of which 16 are contingency beds). Western Isles Hospital was opened in 1992 with a range of acute hospital specialties such as general surgery, paediatrics,

maternity and psychiatry. The hospital also includes diagnostic facilities, day hospital (ambulatory care unit), laboratory, allied health professionals and other services.

About this inspection

We carried out an unannounced inspection to Western Isles Hospital, NHS Western Isles from Tuesday 3 to Wednesday 4 September 2024 using our safe delivery of care inspection methodology. We inspected the following areas:

- acute assessment unit
- ambulatory care unit
- day surgery unit
- emergency department
- Erisort ward
- medical ward 1
- medical ward 2, and
- surgical ward.

During our inspection of Western Isles Hospital, 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 Western Isles 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.

We held several virtual meetings with key members of NHS Western Isles during September and October 2024 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 Western Isles and in particular all staff at Western Isles Hospital 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'.

We observed staff working hard to provide compassionate and responsive care with all patients being complimentary about the care provided. The hospital environment was clean and well maintained. Mealtimes were calm and well led with patients receiving assistance with hand hygiene prior to meals and with eating and drinking where required.

As a result of issues identified during our inspection, we wrote to NHS Western Isles on two occasions during our inspection to raise significant concerns. Concerns related to the availability of children's nurses, staff trained in paediatric immediate life support and systems and processes for the safe care of acutely unwell, deteriorating patients. NHS Western Isles responded to our requests for further information in relation to these concerns. Conflicting information has been provided in relation to the number of suitably trained staff in paediatric immediate life support and immediate life support and there remains a lack of assurance in this area. Furthermore, we raised concerns about staff training in child and adult support and protection and regarding fire training compliance and maintenance for firefighting equipment in Western Isles Hospital. We were informed that fire extinguishers had been serviced following our concerns being raised. However, we did not receive assurance in child support and protection training, adult support and protection training and fire training compliance.

Additionally, we have raised concerns regarding governance processes, in relation to the development and review of policies and procedures. We received feedback on this from NHS Western Isles, which will be discussed within the report.

Other areas for improvement have been identified at Western Isles Hospital. These include the safe storage of medication and cleaning products as well as the completion of patient documentation.

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

This inspection resulted in eight areas of good practice and 22 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.

We expect NHS Western Isles 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: https://www.healthcareimprovementscotland.scot/

Areas of good practice

Domain 1	
1	Effective emergency department working to ensure patients receive the right care in the right place by following Scottish Government emergency department signposting and redirection guidance (see page 22).
2	The hospital environment was visibly clean and well maintained (see page 22).
3	Staff were observed delivering compassionate patient care (see page 22).

Domain 4.1	
4	Mealtimes were well coordinated and patients received timely assistance with hand hygiene before meals and assistance with eating (page 34).
5	All equipment examined was clean and stored safely ready for use (page 34).

Domain 4.3	
6	NHS Western Isles has introduced a variety of development opportunities for senior charge nurses (page 38).

Domain 6	
7	All observed interactions were professional, friendly and respectful (see page 41).
8	Patients speak highly of the care received (see page 41).

Requirements

Domain 1	
1	NHS Western Isles must ensure as a matter of urgency all staff are provided with and complete the necessary paediatric and adult immediate life support training to safely carry out their roles (see page 23). 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 Western Isles must ensure improvement actions within fire risk assessments are carried out, fire safety equipment is tested and maintained to ensure safe working and staff have complete mandatory fire training (see page 23). 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).
3	NHS Western Isles must ensure all staff have completed appropriate levels of adult support and protection and child support and protection training relevant to their roles (see page 23). This will support compliance with: NHS Public Protection Accountability and Assurance Framework (2022) and Health and Care (Staffing) (Scotland) Act (2019).

Domain 2	
4	NHS Western Isles must ensure that senior management and leadership oversight and support is effective, to reduce the risks for staff and patients and support staff wellbeing (see page 28). This will support compliance with: Health and Social Care Standards (2017) Criteria 4.23 & Quality Assurance Framework (2022) Criteria 2.3, 2.6 and 5.5
5	NHS Western Isles 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 29).

	This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 3.1 and Learning from adverse events through reporting and review: A national framework for Scotland (2019).
6	NHS Western Isles must have effective processes in place for communication and dissemination of information from hospital wide huddles (see page 29). This will support compliance with: Health and Social Care Standards (2017) Criterion 2.6.
7	NHS Western Isles must ensure staff are supported within their role and that concerns raised by staff are acted upon (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 (legislation.gov.uk).
8	NHS Western Isles must ensure effective and appropriate governance approval and oversight of policies and procedures are in place (see page 29). This will support compliance with: Health and Social Care Standards (2017) Criterion 1.24 and Quality Assurance Framework (2022) Indicator 2.6.

Domain 4.1	
9	NHS Western Isles must ensure use of a selection criteria within risk assessments to support placement of patients within additional beds that are used during periods of extreme system pressure (see page 34). This will support compliance with: Health and Social Care Standards (2017) Criterion 1.23, 1.4, 2.11, 2.32, 4.14 and 5.22 and Quality Assurance Framework (2022) Indicator 2.1.
10	NHS Western Isles must ensure all patients have access to call bells (see page 34.) This will support compliance with: Health and Social Care Standards (2017) Criteria 4.11, 5.2, 5.3 and 5.4 and Healthcare Improvement Scotland Quality Framework (2018).
11	NHS Western Isles must ensure that all patient care documentation is accurately and consistently completed (see page 34). This will support compliance with: Quality Assurance System (2022) Criterion 4.1 and relevant codes of practice of regulated healthcare professions.

12	NHS Western Isles must ensure the safe storage and administration of medicines at all times (see page 34). This will support compliance with: the Royal Pharmaceutical Society and Royal College of Nursing Professional Guidance on the Administration of Medicines in Healthcare Settings (2019) and relevant codes of practice of regulated healthcare professions.
13	NHS Western Isles must ensure that all staff carry out hand hygiene at appropriate moments and use personal protective equipment in line with current guidance (see page 34). This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022).
14	NHS Western Isles must ensure all staff comply with the safe management of waste including sharps (see page 34). This will support compliance with: National Infection Prevention and Control Manual (2023).
15	NHS Western Isles must ensure cleaning products are stored safely and securely (see page 34). This will support compliance with: National Infection Prevention and Control Manual (2023).

Domain 4.3

16	NHS Western Isles must ensure that decision making regarding staffing risks and mitigations are open and transparent and aligned with patient acuity (see page 38). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
17	NHS Western Isles must consider skill mix, dependency and complexity of patients to support staff to apply professional judgement when declaring safe to start (see page 38). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

18	NHS Western Isles must ensure a robust system in place consistently to assess and capture real time staffing across all professions to ensure clear management oversight (see page 38). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
19	NHS Western Isles must ensure clear real time staffing data is consistently recorded and communicated and clear escalation processes and any mitigations/inability to mitigate are recorded clearly and accurately (see page 38). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
20	NHS Western Isles must ensure that there are processes in place to support the consistent application of the common staffing method, demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement. This includes that the principles of the **c**ommon **s**taffing method are applied, including having a robust mechanism for feedback to be provided to staff about the use of the common staffing method, and staffing decisions made as a result (see page 38). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

Domain 6

21	NHS Western Isles must ensure patient dignity is maintained at all times. This includes but is not limited to access to shower facilities for all patients (see page 41). This will support compliance with: Quality Assurance Framework (2022) indicators 6.1 and 6.4 and Health and Social Care Standards (2017) criteria 1.4, 1.19 and 5.2.
22	NHS Western Isles must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures (see page 41).

This will support compliance with: Quality Health and Social Care Standards (2017) criterion 2.7.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

At the time of this inspection NHS Western Isles, like much of NHS Scotland, was experiencing ongoing pressures including increased hospital capacity, reduced staff availability and increased patient acuity. Wards visited were clean and the environment was well maintained.

At the time of this inspection Western Isles hospital was experiencing similar challenges to hospital boards in mainland Scotland including staffing shortages, high acuity of patients and increased patient numbers. As we have seen in several other NHS boards this has resulted in the use of additional contingency beds. During our onsite inspection we observed that the hospital was operating between 115% and 119% capacity for acute beds. Western Isles Hospital has a capacity of 52 acute funded beds with 16 adult inpatient contingency beds. During discussions with hospital managers, it was identified that there are currently 14 delayed discharges within the hospital due to delays with patient care packages and awaiting placement within care homes. During the onsite inspection, despite wards being busy with high acuity and additional patients, staff were observed working together to deliver care to patients.

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. Across NHS Scotland for the week ending 25 August 2024, 66.5% of patients were seen within the four-hour target with 98.1% of patients seen within the four-hour target in the emergency department at Western Isles Hospital. Further information can be found here.

On the first day of our onsite inspection, we observed that the longest time to first assessment by a clinician was under 30 minutes. We observed one patient who had been receiving care in the department for six hours whilst awaiting availability of a bed and transfer to the high dependency unit. We were advised by both emergency department staff and hospital managers that there are no delays in patients being transferred from arriving ambulances into the department. Through evidence received from NHS Western Isles, we did not identify any incidents related to ambulance delays, triage or emergency department delays.

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

guidance - gov.scot (www.gov.scot). As part of evidence requested, we asked NHS Western Isles for its redirection policy. We can see from this that patients are assessed by an emergency nurse practitioner and decisions made regarding redirection with the involvement of senior emergency department medical and nursing staff. An emergency nurse practitioner is a trained nurse who has undergone extensive further education and practice to enable them to assess, diagnose and manage a variety of minor injuries such as sprains, burns and minor infections. The emergency nurse practitioner is based within the emergency department and although working independently, can gain support and guidance from medical staff within the department. We can see from the redirection guidance that a defined group of patients can be identified and considered for signposting/redirection, using a criteria based trigger. These include any patients with an illness or condition normally treated by their primary care team, patients who have already seen their primary care team or have an ongoing treatment plan in place and patients who are presenting with a condition that they have had for three or more days. Redirection guidance for Western Isles Hospital includes, but is not exhaustive of, community optometry, NHS24, pharmacy and dentist.

Additionally, within the hospital, NHS Western Isles display posters and run a campaign called 'knowing where to turn' which supports patients to make the correct decision as to who should be contacted in different occasions of requiring healthcare input. This signposts patients and carers to a variety of services such as dentist, pharmacist and general practitioners.

Evidence provided also details the Scottish Ambulance Service pathways hub which provides details on pathways available to reduce the need for hospital treatment and attendance at the emergency department. Patients are discussed with a senior clinician who can assist with decision making to ensure patients receive care in the appropriate environment. Pathways include the urgent care team and referral to the hospital at home team who provide a short term targeted intervention with a level of hospital care within the patient's home. Services provided by hospital at home include regular review by medical and nursing staff, blood sampling and monitoring and administration of intravenous medications such as intravenous antibiotics or intravenous fluids. Additional pathways include palliative and end of life care advisory and coordination service to assist with access to necessary care with Macmillan teams, referral back to primary care team for pre-existing and chronic conditions and medication reviews. Other pathways are onward referral and support to access mental health support and guidance and out of hours, where a senior clinician would provide support to attending Scottish Ambulance Service staff to assist with decision making.

Triage is an essential part of emergency care. On a patient's arrival to the emergency department, the individual responsible for triage assesses the patient's needs and assigns the priority of treatment required. There is no standardised triage system in Scotland. However, the Royal College of Emergency Medicine advises that triage

should occur within 15 minutes of presentation. More information can be found at initial assessment of emergency department patients - Royal College of Emergency Medicine. During our onsite inspection we observed that there were no delays in patient triage. As part of this inspection, we asked NHS Western Isles to provide us with any incident reports submitted by staff for the three months prior to this inspection in relation to patient safety. We can see from these that none have been submitted in relation to delays in triage times.

The emergency department operates a see and treat model. The see and treat model is a process where patients with minor conditions are assessed and provided with treatment at the same time as opposed to being assessed and then waiting in the waiting room for further treatment. At the time of our inspection one patient was being reviewed under this model due to a hand injury. We were advised by hospital managers that, where capacity within the department allows, patients are taken directly to an appropriate consulting room to be assessed by either the emergency nurse practitioner or doctor. We were also advised that ambulance patients are prioritised depending on clinical need.

During our inspection of the emergency department all patients were being cared for in designated cubicles. Due to the size of the department, there are no designated major or minor injury areas. There are two side rooms, one resuscitation room with one bed and one contingency bed within the corridor. Inspectors asked what processes are in place when demand outweighs capacity. Inspectors were told that there is a standard operating procedure in place for an escalation process should this occur. From the standard operating procedure, we observed that there are three trigger stages for escalation. These trigger stages depend on the capacity within the emergency department with three corresponding action cards. Triggers commence when the time for clinical assessment and decision making exceeds two hours. Actions to be taken include contacting the consultant responsible for care and attempting to expedite results such as laboratory or radiology. Mitigations that can be put in place include diverting any expected patients to the acute assessment unit, referring to the bed management team and considering further use of contingency beds. Throughout all stages of escalation, the clinical support nurse, lead nurse and on call manager should be kept informed. We did not witness this standard operating procedure being implemented as it was not required whilst on inspection.

The resuscitation area within the emergency department is used for patients who have a higher level of clinical dependency and therefore require a higher level of monitoring, nursing and medical care. We asked hospital managers about the processes in place to maintain patient safety if a patient's clinical condition necessitates care in the resuscitation area when there is no available space. We were told other areas within the hospital would be utilised such as theatres, theatre recovery and the high dependency unit. However, in order to maintain patient safety this system relies on staff awareness of the systems and processes in place for such circumstances. NHS Western Isles could not provide any process, policy or standard

operating procedure to support staff when managing the placement of patients requiring higher levels of care. We did not see any reported patient safety incidents in relation to this in evidence provided. A requirement has been given within domain 2 to support improvement in relation to governance.

During our onsite inspection, we were told of plans to increase the capacity of the emergency department with work due to commence in March 2025.

Western Isles Hospital has an acute assessment unit which is open from 08.00 – 21.00. Patients are referred by their general practitioner directly to the unit for assessment by a clinician as opposed to attending the emergency department. Staff within the emergency department told inspectors that the implementation of the acute assessment unit service has significantly reduced the footfall within the emergency department, reporting that approximately 30% of referrals require admission to hospital meaning admission through the emergency department is greatly reduced. The acute assessment unit is discussed later in this report.

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). This also states that all patients should have a paediatric early warning score recorded on arrival and that any infant or child with a score above four should receive a medical review within fifteen minutes. The paediatric early warning score is a system that measures physiological parameters such as heart rate, respiratory rate and blood pressure as well as recording staff or carer concerns.

We asked NHS Western Isles for nursing staff training compliance for the paediatric immediate life support course for both the ward where paediatric patients are cared for and the emergency department. This course is developed by the Resuscitation Council UK for health professionals who may have to manage and treat paediatric patients in an emergency. From evidence provided training compliance for the nursing staff within the ward is 12.5% for paediatric immediate life support and 8.3% trained in paediatric advanced life support, with 65% of emergency department nursing staff trained in either paediatric immediate or advanced life support in the emergency department.

During the inspection staff and senior managers explained challenges in ensuring a children's nurse is available during every shift. There are currently four substantive trained children's nurses who work in Western Isles Hospital; one in the emergency department and three within the ward. We were also told about a trained children's nurse employed through the staff nurse bank, who also works shifts within the hospital. We asked NHS Western Isles for a copy of its' standard operating procedure or risk assessment for use when there is no paediatric nurse on duty. However, this

could not be provided as there are no formally agreed processes in place. Senior managers advised that a standard operating procedure and risk assessment are under development which will then be presented at the appropriate governance committee meeting. However, there is currently no target publication date for this.

Within evidence provided there were multiple incidents submitted by staff in relation to the care of paediatric patients including the lack of availability of registered children's nurses. During the onsite inspection, ward staff raised concerns in relation to caring for paediatric patients without having undergone further training, particularly in relation to the administration of medication including intravenous antibiotics. We discussed these concerns with senior managers who advised a clinical support nurse is always on duty to support staff, along with 24 hour availability of a paediatrician and anaesthetist. Within Western Isles Hospital the role of the clinical support nurse is to provide senior leadership, clinical input and support within the hospital. During discussions with senior managers, we were advised that the anaesthetist and paediatrician on call were within 15 minutes of the hospital if not on site at the time.

As discussed earlier in this report, we wrote to NHS Western Isles on two occasions to raise concerns. However, from the information provided we found that although all of the clinical support nurses had previously completed training, this qualification had expired. This meant that no members of the clinical support nurse team held an up to date paediatric immediate life support certificate and only 15% of the team hold a European paediatric advanced life support certificate.

We sought further clarification from NHS Western Isles highlighting our concerns regarding the conflicting evidence we had received. In response to our concerns NHS Western Isles senior managers informed us that all registered general and registered children nurses working on the ward are expected to have completed both immediate and paediatric immediate life support training by 3 December 2024. They have provided information of three planned training dates for staff to attend paediatric immediate life support training. Each date has eight available places and hospital managers advised that budget has been made available to provide supplementary staff to ensure the ward is covered safely to allow staff to attend. Additionally, there are plans in place to deliver paediatric early warning score training to health care assistants. We were also advised that there are plans with the clinical skills team to reintroduce the 'Paediatric Aims' course which equips staff with the appropriate skill set to safely identify, assess and manage a deteriorating paediatric patient and provide the right care at the right time. However, in further information provided we were told it was hoped training in immediate life support and paediatric immediate life support would be available for the clinical support nurse team early next year although these training dates have not been confirmed. We remain concerned that, that NHS Western Isles have highlighted the clinical support nurses remain the first point of contact when staff have concerns about a paediatric

patient's safety. However, they have not yet confirmed these training dates. A requirement has been given to support improvement in this area.

During our onsite inspection staff told us that clinical support nurses are available should assistance be required when there is no paediatric nurse on duty. However, the incident reports we reviewed included one reported incident where a first year paediatric student nurse who was working a supplementary shift as a healthcare support worker, was given responsibility for carrying out the patient's paediatric early warning score monitoring. We discussed this incident with senior managers who explained that this had been an isolated situation in an exceptional circumstance. We were told that a member of the nursing staff had raised concerns that they did not feel suitably trained to safely care for paediatric patients and it had been escalated to the senior executive on call, who attended the ward and felt this was the safest option for the patient. Senior managers advised that there was a clinical support nurse on duty for the hospital should any escalation of condition or additional assistance be required. Senior managers also told us that there was no adverse event as a result of this and we did not observe any recorded patient harm in the patient safety incident.

We were advised by senior managers that if a paediatric patient's clinical condition is deteriorating whilst in the emergency department, they will remain in the department whilst awaiting transfer off island. If a paediatric inpatient's condition deteriorates the clinical support nurse will provide support until the patient is either stabilised or transferred off the island. Alternatively, depending on available skill mix, any paediatric patient awaiting retrieval may also be transferred to and cared for in the emergency department until transferred off island. As part of evidence requested, we asked for the NHS Western Isles paediatric retrieval pathway. We were advised that NHS Western Isles uses ScotSTAR (Scottish Specialist Transport & Retrieval) guidance and documentation for support whilst awaiting retrieval. ScotSTAR is a national service for safe and effective transport and retrieval of critically ill children and adults throughout Scotland. Telephone numbers for direct links to consultant medical staff at both the Royal Hospital for Children Edinburgh and Royal Hospital for Sick Children Glasgow are available and accessible for all Western Isles Hospital staff to enable them to seek advice. Additionally, within the ScotSTAR guidance there are QR codes with quick links to guidelines, respiratory documentation, links and drug calculations.

While we were pleased that NHS Western Isles had provided information on planned training events, we remain concerned about the conflicting responses by NHS Western Isles senior managers to our concerns in relation to staff training compliance.

We sought further assurance from senior managers in relation to the availability of paediatricians during planned and unplanned leave. We were advised that at least one of the two paediatricians is always available on the island. We were told locum

consultants are contracted on the basis that there is 24/7 cover using a 1:2 on call rota. A second locum would be required to cover when there is planned leave. When there is unplanned leave, the emergency department speciality doctor would be expected to cover as they are all trained in paediatric immediate life support and European paediatric advanced life support. NHS Western Isles advised that where there are not enough suitably trained staff with the required knowledge and skills to care for both paediatric and adult patients, the patients would be transferred off island.

The Care Assurance and Improvement Resource dashboard is a central data repository and data visualization dashboard created by NHS National Services Scotland to support the aims of Excellence in Care. The dashboard stores data centrally, submitted on a monthly basis by health boards and provides benchmarks and measurement in relation to Excellence in Care targets. Within this data NHS Western Isles has reported a reduction in compliance in relation to paediatric early warning score escalation. The data indicates that since December 2023, 11 out of 31 cases failed to be escalated appropriately. This could include onward review by medical staff or clinical support nurses or that observations were not recorded within a specified time. We discussed this with senior managers who told us there had not been any adverse events in relation to missed escalation of scores. Through evidence reviewed we did not see any reported incidents in relation to inappropriate escalation of paediatric early warning scores. At the time of the report, it is unclear as to why these were not escalated. NHS Western Isles advised it will investigate this.

During our virtual discussion with hospital managers we were advised that NHS Western Isles is currently working to improve submissions to the care assurance and improvement resource dashboard, particularly in relation to missing/incomplete documentation submissions and working to improve record keeping. We can see in evidence provided that there is a new roll out of a 'how we are doing' board within each ward which displays all excellence in care information relating to that area. Information displayed includes falls, pressure ulcers, student feedback score and national early warning score 2 compliance including paediatric early warning score compliance where relevant.

As described earlier in this report paediatric inpatients are cared for in a dedicated bay or single rooms in an adult inpatient ward. Through several incident reports we observed occasions where adult patients within the ward have become distressed, confused and aggressive. During our virtual discussion with senior managers, we asked how any potential risks from both adult patients and paediatric patients being cared for in the same ward area are mitigated. We were advised that paediatric patients were accompanied by an adult at most times during their hospital stay. However, NHS Western Isles acknowledged that there may be occasions when the paediatric patients are unaccompanied. Hospital managers advised that where an adult patient becomes confused and shows signs of aggression, they would look to relocate them to another ward to ensure paediatric patients are not cared for within

the same area. Currently there is no risk assessment in place to support the movement of patients displaying signs of confusion and aggression. Additionally, further movement around the hospital may cause increased confusion for the patient. We asked NHS Western Isles for information on staff training compliance with child support and protection and adult support and protection training. However, staff training compliance rates provided were low. Within the emergency department 63.63% of staff have completed level 1 training in relation to both adult support and protection and child support and protection. In the ward where paediatric patients are cared for, 17.24% of staff have completed level 1 adult support and protection training and 13.79% of staff have completed level 1 child support and protection training. A requirement has been given to support improvement in relation to both child support and protection training and adult support and protection training monitoring and compliance.

As part of discussions with senior managers, we were advised that clinical support nurses also form part of the cardiac arrest team. Senior managers have explained the clinical support nurse team are the first point of contact for any staff member caring for a deteriorating patient. We sought further assurance regarding the training of clinical support nurses in relation to adult immediate and advanced life support. From the data provided we observed that although some of the clinical support nurse team had previously complete training, this qualification had expired. Therefore, currently no members of the team hold a valid immediate life support certificate and four clinical support nurses hold a valid advanced life support certificate. A requirement has been given to support improvement in this area.

All staff should be aware of fire evacuation processes, maintain up to date fire safety training modules and fire safety assessments should be maintained accurately with all recommendations and actions noted. As part of the evidence provided by NHS Western Isles, we observed that fire safety visits had been carried out and assessments updated in clinical areas shortly after our onsite inspection. Within the assessments we were able to identify common themes of non-compliance in relation to fire safety including the servicing of fire extinguishers, emergency lighting testing and the storage of oxygen and electrical equipment in the same cupboard. The fire risk assessments provided documented that training compliance was low and did not comply with NHS Western Isles fire safety policy. It was also noted that fire walkarounds within clinical areas had not been carried out. There were also two storage areas mentioned where oxygen cylinders and other flammable items were stored alongside electrical items which were charging within a room with no fire detection.

During our virtual discussion with senior managers, we raised concerns surrounding the outcomes of the fire safety risk assessment such as the servicing of firefighting equipment and highlighted low compliance rate of staff training. However, many of the senior managers responsible for patient care were unaware of the fire safety risk assessments that had been supplied to the inspection team. Senior managers did

inform us that the servicing of fire extinguishers is undertaken by an external contractor however there had been delays in servicing these. We were advised this would be actioned immediately.

We can see from evidence provided that staff fire training compliance rates are low with only 37% of staff up to date with annual training and 14% up to date with three yearly fire training. We requested evidence of tabletop exercises in relation to fire safety and evacuation. This was not available as there was no record of these having been carried out. We requested evidence of fire safety assessments carried out prior to the September 2024 assessment. From this evidence we observed fire safety assessments carried out in September 2023 highlight similar issues such as low staff training compliance, lack of fire drills and walkthroughs and storage of some equipment in areas without appropriate fire detection. We asked NHS Western Isles if detection within neighbouring rooms would alert to any fire within these areas. We were advised that there are detectors directly outside the storeroom. However, these would not be sufficient and a detector would be required within the storeroom. Through evidence submitted we were advised that talk through fire drills are carried out as an element of the training. However, from evidence received we observed that these are yet to be carried out in all departments throughout the hospital and currently there are no plans for these. Our concerns in relation to fire safety were also highlighted in our letter of serious concern. In response to this, NHS Western Isles provided assurance that fire extinguisher servicing would be complete by 21 October 2024. NHS Western Isles have confirmed that this has been carried out. Evidence was also provided for fire lighting, damper and alarm testing and a fire risk assessment had been shared with senior clinical staff and the estates team for each area. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 1	
1	Effective emergency department working to ensure patients receive the right care in the right place by following Scottish Government emergency department signposting and redirection guidance.
2	The hospital environment was visibly clean and well maintained.
3	Staff were observed delivering compassionate patient care.

Requirements

Domain 1	
1	NHS Western Isles must ensure as a matter of urgency all staff are provided with and complete the necessary paediatric and adult immediate life support training to safely carry out their roles.
2	NHS Western Isles must ensure improvement actions within fire risk assessments are carried out, fire safety equipment is tested and maintained to ensure safe working and staff have complete mandatory fire training.
3	NHS Western Isles must ensure all staff have completed appropriate levels of adult support and protection and child support and protection training relevant to their roles.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

We observed that despite being busy, staff were working hard to deliver care. However, we received varied feedback from staff regarding support from senior managers, with some staff describing a disconnect between ward staff and senior management.

Some of the areas visited were calm and well organised with visible leadership. However, within one ward we visited there was no visible leadership within the ward. Staff spoke with inspectors and raised concerns around workload, skill mix, patient acuity and difficulty taking scheduled breaks. Some staff told us that they often do not receive scheduled breaks on time, or in some cases are not able to take any break throughout their shift. Within the incident reports we reviewed we observed several instances where staff were not able to take scheduled breaks. Staff were often late leaving shift due to the acuity within the ward and shortages with staffing. We raised this with senior managers who advised they were unaware of staff remaining late following shift completion or staff being unable to take breaks and that this had not been escalated. Managers advised that staff should contact clinical support nurses who, on most occasions can assist with ensuring breaks are taken such as bringing food to the ward staff. However, the challenge remains for staff to have allocated breaks away from work. We were concerned that senior manager expectations described to us, was that staff in wards known to senior managers to be understaffed with high acuity patients, were expected to raise on a shift by shift basis if there were unable to take their scheduled break.

In one ward we observed that staff were under significant pressure with staff describing to inspectors that they felt increased levels of stress due to the acuity and specialty of the patients in this ward and staffing skill mix. This is a dedicated COVID-19 ward and is not within the hospital's funded establishment and is opened on an as required basis. This means that there are no substantial staff allocated to the ward resulting in staff from other areas being moved to this ward. All patients who test positive for COVID-19 are transferred here then the ward functions as a cohort area. Through discussions with staff in this ward it was identified that staff regularly do not leave on time following completion of their shift and frequently are unable to take scheduled breaks. Additionally, staff describe morale being low, with a lack of senior management oversight and a culture of staff not feeling listened to or supported by senior managers. A requirement has been given to support improvement in this area to ensure leadership oversight and support staff wellbeing.

Several staff we spoke with described feeling overwhelmed with workload, staffing shortages and increased patient acuity. This was also reflected in several incident reports submitted by staff. There may also be an extent of under reporting of incidents as staff advised they are often too tired to stay following the end of their shift to complete incident reports. Staff report feeling under significant pressure with a detrimental effect on staff wellbeing and patient safety. The majority of staff we spoke with described feeling well supported by their lead nurse. However, felt a lack of support from managers above this level.

We raised these concerns with senior managers and were told about improvement actions that were being undertaken. These include additional support from specialist nurses such as the clinical support nurses and non-clinical staff. We were provided with the staffing escalation plan for both in hours and out of hours. This standard operating procedure details the steps which should be taken to try to mitigate any staffing shortfalls and how this should be escalated where mitigation was not possible**.** We were also provided with evidence of plans for recruitment of additional staff to support safe staffing.

We reviewed incident reports relating to patient safety incidents across Western Isles hospital including the COVID-19 ward. Within these we observed an incident where patients were transferred to the ward, from the high dependency unit following a positive COVID-19 test result. We observed evidence of an incident where a patient moved here from the high dependency unit became unwell. However, the correct emergency equipment including medication was not available in this ward. Further challenges were highlighted in relation to the emergency team's ability to gain access to the ward. We sought clarification from NHS Western Isles in relation to access and if the ward was locked at the time. NHS Western Isles advised the ward was not locked and advised how access can be obtained via a link corridor which was erected at the start of the COVID-19 pandemic. This a temporary structure with restricted access. We were advised that there is a blank access card for emergency access from medical 2 and Erisort which can be used in the event of emergency, staff have been

reminded this is there and the process for use. Additionally, there is now an access card attached to all cardiac pagers. However, staff are reminded that routine access would be through the main ward doors.

During the virtual discussion we asked senior managers if there had been a significant adverse event review carried out or changes in practice following this incident. The learning from adverse events national framework indicates that all adverse incidents should be reviewed. The level of the review will be determined by the category of the event and is based on the impact of harm, with the most serious requiring a significant adverse events review. Further information on the national framework can be found at Learning from adverse events through reporting and review – A national framework for Scotland – Healthcare Improvement Scotland. We were advised that a significant adverse event review had not been carried out although a debrief was held with staff the following week. Recognition of staffing challenges and miscommunication between the teams of staff was noted. In evidence submitted we observed plans to ensure all staff have emergency access, equipment is stocked and ready for use and the senior charge nurse within the ward is working closely with the operating department practitioner to clarify roles and responsibilities in case this situation occurs again. The operating department practitioner works across theatres, anaesthetics and recovery, providing additional support to the anaesthetist and operating theatre staff in the preparation of patients and equipment prior to surgery, as well as during the recovery period. However, within Western Isles Hospital the operating department practitioner are also part of the emergency team.

In addition to the inspection report findings, Healthcare Improvement Scotland understands that improvement work is underway to address a risk within the critical communication process for the identification and timely response to patients that are deteriorating. A potential delay in emergency teams responding to a patient and ultimately chain of survival has been identified due to teams calling the switchboard rather than 2222 to alert. Improving the identification and response to the management of the deteriorating patient forms part of the Acute Adult Scottish Patient Safety Programme. Improvement support from the Scottish Patient Safety Programme to address this risk has been offered to the NHS board.

During our inspection we were able to attend the morning and afternoon medical handover followed by the hospital safety huddle. The medical handover was led by the clinical support nurse who had worked the nightshift and would hand over any concerns, such as patients awaiting retrieval off island or any patients who had been unwell, requiring input overnight. All junior doctors as well as consultants attended this handover ensuring medical staff had a comprehensive overview of patients throughout the hospital. At the start of the hospital safety huddle, staff were asked if any areas have safety concerns or any significant events overnight. None were highlighted during our onsite inspection. The safety huddle was attended by nursing colleagues as well as colleagues from allied health professions including physiotherapy, occupational therapy and radiology and infection control. However,

there was no medical representation at this meeting. The hospital safety huddle followed a structured template and sought to address areas of concern. We observed the hospital safety huddles focused on flow and capacity within the hospital as opposed to patient dependency acuity and staffing skill mix. Additionally, we observed that staffing decisions were often based on the number of available staff in each area, as opposed to the dependency or acuity of the patients, skill mix or professional judgement of actual staffing levels. Skill mix required to support the delivery of safe and effective care was not discussed. During the huddle, areas that declared they were not safe to start were scored as 'red'. However, there did not appear to be any in depth discussion regarding the reasoning for high acuity/red areas or any mitigations put in place. This will be discussed further in domain 4.3. A requirement has been given to support improvement in relation to open and transparent conversations about staffing.

At the time of this inspection safety huddles or ward based safety briefs were not carried out within ward areas. Some staff we spoke to told inspectors they do not feel informed following the outcome of hospital wide huddles. Staff also do not feel informed of any mitigations or actions taken as a result of declaring not safe to start, either as a result of staff shortages, patient dependency or acuity. We asked senior managers about the process for sharing safety information with staff in ward areas. We were advised this varies from ward to ward and there is no formal process to support this being carried out. We were advised there would be an expectation that the individual attending the huddle would feed back any relevant points to staff on wards. Following our discussion with senior managers we have been informed of a new template for ward based safety briefs which will be rolled out to each clinical area from 14 October 2024. We observed evidence of this template which included the topics and high risk concerns for daily discussion such as patients with similar names, any environmental changes like equipment and staffing concerns. There is also space for staff to raise any other concerns or issues and for feedback following the hospital huddle to ensure key points are communicated. Although this is now being implemented, a requirement has been given to support improvement in relation to feedback and information sharing from hospital huddles.

We discussed with senior managers the process for reviewing incidents reported and were advised that any learning is shared with wider groups at hospital wide huddles. Additionally, any learning from incident reports is presented in a report at the learning review group, shared at senior charge nurse forums and reported through governance structures. We were provided with evidence of reports sent to the learning review group. These highlight the number, type of incidents and provide a brief summary of learning for incidents such as slips, trips and falls, medication, violence and aggression, sharps injuries and any staffing accidents/near misses. This group appears to be a valuable link for sharing information across departments and sites as the other hospitals in NHS Western Isles are also considered.

From evidence provided we were able to identify recurring themes in the staffing incident reports, particularly in relation to the lack of paediatric trained nurses and staff shortages and reduced skill mix in other wards. Staff reported that they often do not receive feedback from incident reports submitted, which in turn deters them from submitting further reports. A requirement has been given to support improvement in learning and feedback to staff following submission and investigation of incident reports.

In one area inspected, staff told inspectors about logistical issues which have a detrimental impact on the delivery of the service. We were told about occasions where the Systemic Anti-cancer Chemotherapy delivery did not reach the island at the scheduled time due to the ferry timings. On these occasions staff sought permission to carry out overtime to ensure patients received treatments. During discussions with the senior charge nurse within the Systemic Anti-Cancer Therapy ward it was advised that permission was sought from the executive on call who gave permission for staff to be paid overtime to ensure patients received their treatment. We have asked NHS Western Isles what contingencies are in place in the event that this may arise in the future. We were advised that this is exceptional circumstances in the event of logistical failure and the permission to authorise overtime where staff are happy to remain on duty, would be sought on a circumstantial basis from the senior manager on call. This would be authorised in a timely manner to ensure that patients receive chemotherapy as per their care plan. Staff within this area raised concerns regarding workload and skill mix, which is felt to be affecting staff wellbeing and resilience. Although appropriate steps had been taken in line with national human resources policies, staff from several wards inspected described scenarios affecting their health and wellbeing.

During our onsite inspection we did not have the opportunity to observe advertising for any wellbeing initiatives for staff to access and utilise. However senior managers informed us of several areas where these are advertised. Senior managers told us about the Employee Assistance Programme which provides staff with access to a variety of support services to support mental health and wellbeing such as counselling and talking therapies. The Employee Assistance Programme is confidential. However, in order to assess how effective the programme is data can be obtained in relation to the number of staff accessing and reasons for access such as mental health support and sleep. Additionally, to support women's health the Once for Scotland Menopause and Menstrual Health workplace policy has been implemented and provisions made for access to free period products throughout NHS Western Isles. Improvements have been made to ensure services are accessible to all staff. There are multiple points of access such as intranet, smartphone applications, internet, social media and leaflet and poster distribution.

NHS Western Isles holds a wellbeing group twice a month where wellbeing initiatives are evaluated, discussed and any improvements suggested. Through evidence provided from the wellbeing group we observed work being completed around

behaviours, attitudes and civility with sessions planned for all departments. These sessions aim to help individuals reflect on behaviours and provide an understanding of the impact they have on others. These sessions were introduced due to the increased pressure upon staff within NHS Western Isles Hospital. Staff and senior managers did not report any incidents in relation to behaviours and attitudes. Additional initiatives include support for band 5 and band 6 banding review applications, cycle to work scheme and webinars in relation to financial wellbeing. The wellbeing group is attended by senior members of staff from NHS Western Isles. While we recognise efforts made by NHS Western Isles to support staff wellbeing, staff have raised concerns detailed within this report, during this inspection. A requirement has been given to support improvement in relation to concerns raised with inspectors by staff.

Evidence provided by NHS Western Isles includes several guidelines and standard operating procedures which are in draft form or currently have no approval date or review date. This includes the NHS Western Isles closed circuit TV policy, which was published in 2013, and the accident and emergency escalation tool and NHS Western Isles signposting and redirection policy. At the virtual discussion senior managers told us the responsibility for reviewing policies lies with the original author. We received evidence in relation to the governance processes for the reviewing and updating of policies and procedures. This included the checklist which should accompany any new or updated policy or guideline. In the checklist it is stated that there is an expectation that there must be a publication date and review date on each document. There is also an expectation that the author will review and update the document on a two yearly basis. This process has not been followed in relation to the documents provided in the evidence. The NHS Western Isles closed circuit television camera policy was approved in 2013 and has not been updated or reviewed since then.

Governance and oversight process were included in our letter of serious concern to NHS Western Isles. In response to this, additional evidence was provided by NHS Western Isles including the policy pathway diagram for the review submission and review process for clinical policies. This identifies that the local service area where the policy was generated is responsible for the policy review. A requirement has been given to support improvement in this area.

Requirements

Domain 2	
4	NHS Western Isles must ensure that senior management and leadership oversight and support is effective, to reduce the risks for staff and patients and support staff wellbeing.

5	NHS Western Isles 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.
6	NHS Western Isles must have effective processes in place for communication and dissemination of information from hospital wide huddles.
7	NHS Western Isles must ensure staff are supported within their role and that concerns raised by staff are acted upon.
8	NHS Western Isles must ensure effective and appropriate governance approval and oversight of policies and procedures are in place.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

Patients appeared well cared for and spoke highly of care received. We observed good team working and support provided by clinical support nurses, and patients received assistance with meals and hand hygiene prior to meals. However, we observed some missed opportunities for hand hygiene and medication cupboards were not always locked.

Due to a requirement for increased capacity within Western Isles Hospital there are additional contingency beds in use in a number of wards and clinical areas. These beds are placed within a multi-bedded room, transforming the room from a four bedded bay to a six bedded bay. Within these contingency beds patients have access to a call bell and privacy curtains are in place around the bed space. As part of our evidence request, we asked NHS Western Isles for the risk assessment/selection criteria for the use of these contingency beds. However, there is currently no formalised process in place to aid decision making in relation to patient placement within contingency beds. A requirement has been given to ensure staff awareness of patient criteria for placement within additional beds.

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 contingency beds NHS boards must ensure patient safety and dignity is maintained for both the patient within the contingency bed but also for the patients within the surrounding beds. Additionally, boards must ensure appropriate placement mechanisms are in place such as a risk assessment or selection criteria.

From evidence provided we observed that operational risks are captured within the organisational risk register. Each risk allocated member of staff responsible for the mitigation of and decision making regarding the risk. The use of contingency beds is recorded on the organisational risk register with concerns in relation to bed spacing and possible transmission of nosocomial infection was recorded as a risk. Mitigations were in place including enhanced cleaning should there be identification of infection, although nursing staff advised they were unaware of any direct outbreak links through use of these contingency beds.

Within the emergency department there was one contingency bed. This was placed within the corridor outside the resuscitation room. Staff explained that when this bed is in use temporary screens are utilised to maintain a degree of privacy for patients. Additionally, inspectors identified within the emergency department that no patients have access to a call bell and in the side rooms there was only access to an emergency buzzer. Inspectors raised concerns in relation to this whilst onsite. We were advised that on the majority of occasions there are staff members in the corridor so patients can access assistance easily. There are occasions where the door may be closed and it may be more difficult for patients to seek assistance. Therefore, a requirement has been given to support improvement in this area.

Several patients had treatment escalation plans in place. A treatment escalation plan is used to record information discussed between patients and healthcare professionals. The plan creates a personalised recommendation for clinical care in emergency situations where a patient is not able to make decisions or express their wishes. However, the subsequent Do Not Attempt Cardiopulmonary Resuscitation form was not completed as the treatment escalation plan indicated. Treatment escalation plans can be used at any time to plan treatment and make recommendations for care. They are important if the patient has a medical condition that might change quickly or are approaching the end of life. Where corresponding documentation is not present this may lead to confusion in an emergency situation and may cause increasing upset to patients, relatives and staff. We raised this with onsite managers who advised they will highlight this throughout the hospital and ensure junior doctors' induction programme highlights it also. A requirement has been given to support improvement in this area.

Additionally, we found that a number of patient risk assessments were not fully complete. This included falls risk assessments, Malnutrition Universal Screening Tools, and the use of bed rail assessments as well as National Early Warning Score 2 not completed in a timely manner due to ward pressures. The National Early Warning Score 2 is a scoring system allocated to physiological measurements such as blood pressure and pulse. Its purpose is to improve the detection and response to patients who are at risk of or have become more unwell. Effective record keeping is a requirement of all registrants and is essential to providing individualised person-centred care. Any inconsistencies in recording could result in missed opportunities to carry out fundamental patient care and may increase the risk of an adverse patient

outcome. Following discussion and evidence obtained we have been able to identify a quality improvement project in relation to all patient documentation with regular auditing. The improvement project seeks to assess documentation at different stages on the patients' hospital journey in relation to medical clerk in, risk assessment completion and discharge planning. Evidence provided indicates, for the three months prior to inspection, that there have been no overall improvements in the completion of these documents. As stated above, a requirement has been given to support improvement in this area.

In one area, inspectors observed that patients' medications had been dispensed and left on the patients' bedside tables. This may increase the risk of error in the administration of the medicine. For example, the medication may be missed or not taken at the prescribed time impacting on the timing of subsequent medication. Additionally, the medication may be ingested by another patient. In several areas inspected we also observed medication storage cupboards and preparation rooms were unlocked, and some medication left unattended. Unsecured medication storage may result in a risk that medication may be taken by a patient or member of the public. We highlighted this to ward staff and hospital managers for action at the time of the inspection.

Due to ongoing pressures within NHS Western Isles, patients may remain in the emergency department for prolonged periods of time. We asked the senior charge nurse what processes were in place to ensure patients who have long stays in the emergency department receive their regular and time critical medication. The senior charge nurse advised where patients bring their own medication with them and if they are not within a cubicle in the department, they are brought in from waiting area and medication is administered either from the patient's own supply or from hospital supply. Through review of incident reports and discussions with staff within the emergency department we did not identify any occasions in which patients missed time critical medications whilst in the emergency department. However, there were several incident reports stating delays with routine patient medication administration within the inpatient wards due to staffing shortages. We asked hospital managers about these incidents, and they were unaware of any adverse events having occurred as a direct result of any delayed administration. A requirement has been given to support improvement in relation to the safe storage and administration of medication.

During our onsite inspection, we observed several mealtimes, the majority of which were well organised with patients receiving their meals in a timely manner and patients receiving assistance where required. We observed that staff were aware of patients' dietary requirements. Additionally, we observed patients receiving assistance to carry out hand hygiene prior to meals and assistance given to eat and drink where required.

Within the emergency department patients receive hot meals from the kitchen whilst it is open. Patients can receive hot soup and sandwiches out with these times. Staff heat up soup for the patients to ensure a hot meal is provided. During our virtual discussion with NHS Western Isles, we discussed this and were advised that in line with Food, Fluid and Nutrition requirements, there is a care box in each department, with tins of soup if needed out of hours. Additionally, the dining room has been extended and part of the area is open at all times allowing staff, patients and relatives access to vending machines and microwaves anytime.

From incident reports submitted we identified slips trips and falls as the highest category of incidents reported. Senior managers told us about improvement work in place to help reduce the number of falls related incidents. We were told of the falls collaborative working with ward staff, health and safety and quality improvement staff which is an improvement project identifying wards which could be 'hot spots' where three or more incident reports are submitted in relation to falls. A deep dive is then carried out on each incident to understand any patterns such as changes in ward environment, attempting to mobilise without footwear or mobilise to toilet. Ward staff are encouraged to complete incident reports in relation to falls during the collaborative as this will provide measurement on the effectiveness of the mitigations put in place. Individual patients are assessed, and appropriate footwear is provided. Signage is in use to encourage patients to obtain assistance to mobilise and a report is shared with the learning review group, quality and safety meeting and health and safety committee.

Standard infection control precautions should be used by all staff at all times to minimise the risk of cross infection. These include patient placement, hand hygiene, the use of personal protective equipment (such as aprons and gloves), management of patient care equipment and the care environment, safe management of blood and bodily fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

Practicing good hand hygiene helps reduce the risk of the spread of infection and should be carried out effectively by all staff within the clinical area at appropriate times. Alcohol based hand rub was available throughout the hospital.

Inspectors observed that there were occasions where staff missed opportunities to clean their hands including before and after contact with patients' surroundings. A requirement has been given to support improvement in this area.

Transmission-based precautions are the additional infection control precautions that should be used by staff when caring for a patient with a known or suspected infection. We observed good compliance in this area. We also observed signage in place to identify which areas required transmission-based precautions.

As previously mentioned, there is one ward within Western Isles Hospital which is routinely unoccupied and used as a COVID-19 ward as required. During the onsite

inspection the ward was in use. Whilst in this ward inspectors witnessed staff wearing masks sessionally in line with previous versions of COVID-19 guidance. During the peak of the pandemic, some personal protective equipment was used on a sessional basis and this meant that these items could be used moving between patients and for a period of time where a healthcare worker was undertaking duties in an environment where there was exposure to COVID-19. The sessional use of personal protective equipment is no longer recommended within guidance. However, during this inspection we observed staff entering and exiting bedrooms and throughout the communal areas within the ward such as nurses station and the kitchen wearing the same personal protective equipment. Personal protective equipment should be removed prior to leaving the patients' environment and carry out hand hygiene prior to donning a fresh fluid resistant surgical mask. Therefore, increasing the possibility of ongoing cross transmission. A requirement has been given to support improvement in this area.

Staff we spoke with confirmed that enhanced cleaning was in place within the ward and where patients discharged/transferred a terminal clean of the room was carried out in line with national infection and prevention guidelines.

Inspectors observed poor compliance with sharps management. This included several sharps boxes not being labelled as per guidelines and sharps and pharmaceutical waste boxes that were over full. Additionally, several sharps' boxes did not have the temporary closures in place. Temporary closures prevent needles or sharps protruding from the boxes, or from falling out if the box is dropped. A requirement has been given to support improvement in this area.

Care equipment can be easily contaminated and a source of transferring infection if equipment has not been effectively cleaned. During our inspection all equipment we checked was clean and stored appropriately ready for use.

We observed reconstituted cleaning products and products were not always stored securely and could be accessed by patients or members of the public. Where cleaning products were reconstituted, they did not have the appropriate labelling in place to inform date and time of preparation. This is not in line with the Control of Substances Hazardous to Health (COSHH) Regulations 2002. We raised this concern at the time of inspection and managers advised they would take this forward to ensure products are stored securely. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 4.1	
4	Mealtimes were well coordinated and patients received timely assistance with hand hygiene before meals and assistance with eating.
5	All equipment examined was clean and stored safely ready for use.

Requirements

Domain 4.1	
9	NHS Western Isles must ensure use of a selection criteria within risk assessments to support placement of patients within additional beds that are used during periods of extreme system pressure.
10	NHS Western Isles must ensure all patients have access to call bells.
11	NHS Western Isles must ensure that all patient care documentation is accurately and consistently completed.
12	NHS Western Isles must ensure the safe storage and administration of medicines at all times.
13	NHS Western Isles must ensure that all staff carry out hand hygiene at appropriate moments and use personal protective equipment in line with current guidance.
14	NHS Western Isles must ensure all staff comply with the safe management of waste including sharps.
15	NHS Western Isles must ensure cleaning products are stored safely and securely.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

We observed good leadership in the majority of areas inspected and senior charge nurses were visible in the majority of wards. Staff described that they feel supported to escalate staffing issues and concerns to ward managers. However, they were unclear how these concerns are acted upon beyond this level.

NHS Western Isles has introduced an electronic staffing system which reports real time staffing requirements based on professional judgement in relation to patient care needs. This provides a traffic light system with red areas having the highest shortfall of staff available to meet patients' needs. This enables informed decisions to be made when redeploying staff to help mitigate risk. This system takes into account

the acuity of the patients versus available staffing numbers. It also allows for professional judgement to be made in terms of required staffing. NHS Western Isles reports high confidence in its systems and processes for assessing and managing real time staffing risk. However, the evidence demonstrated low compliance with safe care live which results in a lack of robust and consistent reporting. Senior leaders state apparent low compliance was due to timing of data input and are taking steps to have more oversight arrangements in place to support consistent data recording.

The electronic staffing systems informs discussions and decisions in relation to staffing and is utilised at their safety huddles. However, during inspection it was observed that during huddles staffing decisions often appeared to be based on planned staffing numbers rather than clinical professional judgement. There was little focus on patient acuity, skill mix and potential mitigating actions for any identified staffing risk. A requirement has been given in relation to consideration of skill mix and patient acuity when declaring safe to start and making staffing decisions.

This system also allows records to be made showing mitigations/actions taken such as redeployment of staff and escalation to lead nurse. We can see in evidence provided that no wards or areas remained 'red' during our onsite visit during this inspection with all initial red areas changing to amber after mitigations were put in place such as redeployment of staff. We were provided with the professional judgement information for the three months prior to the inspection which details actions taken in relation to shortages within clinical areas. This is where mitigations and the inability to mitigate are recorded. From this we were able to see that from 99 instances initially raised, 13 remained red due to the inability to mitigate the risks. We asked senior managers what the process is when red flags cannot be mitigated. We were advised that the clinical support nurse would visit the affected area to identify if any further support can be provided at the time and ensure shifts are sent to bank as well as ward areas contacting their own staff to ascertain if they can come in. Staff reported to inspectors that they often do not receive feedback in relation to redeployment of staff or the inability to mitigate shortfalls. Therefore, a requirement has been given to support open and transparent decision making relating to this.

We identified instances through staffing related incident reports where staff reported concerns for both patient and staff wellbeing due to staff shortages. Incident reports also highlighted multiple occasions where the senior charge nurse was required to take a clinical caseload on the ward as opposed to having supervisory management time as part of mitigation for staffing shortages. We discussed this with senior managers who explained that the senior charge nurse works in a primarily supervisory role and are excluded from the safe care calculations. This supports the team to deliver high quality care in a non-case holding capacity. If required to take a clinical caseload senior charge nurses will go from 'excluded' in calculations to 'included.' Therefore, NHS Western Isles is able to monitor occasions where senior charge nurses are case holding more easily. Senior managers advised that this process ensures that senior charge nurses will have the adequate time to carry out

management duties, as set out in the Health and Care (Staffing) (Scotland) Act 2019. During our onsite inspection several senior charge nurses advised that they are often required to take a clinical caseload due to staffing shortages and to support nursing teams. However, no concerns regarding the lack of time to lead was mentioned to inspectors.

Senior managers told us about additional learning and development opportunities for senior charge nurses. These include training in relation to leadership skills, human resource themed drop-in sessions such as sickness absence management, annual leave and the reduction in working week. Where the individuals are unable to attend the sessions, they will be recorded and uploaded to a Microsoft Teams channel to ensure access for all.

Staff told inspectors of the challenges of staffing at times with some areas reporting they were short of staff on a regular basis, which staff described as disheartening. Staffing challenges include staff vacancies and sickness resulting in the need for increased use of supplementary staff. However, due to the unique challenges faced by NHS Western Isles the availability of supplementary staff was significantly reduced. Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency.

We observed other professional groups, such as physiotherapy, pharmacy and radiology staff attended the huddle. There is no real time staffing recording of these groups. During the staffing discussion it was highlighted by NHS Western Isles that there had been a rapid deployment of SafeCare system throughout all groups including allied health professionals such as physiotherapists and occupational therapists. However, this process has not been as straightforward as anticipated. There are challenges with recording of patient acuity to provide a true reflection of staffing shortages within the system for allied health professionals and work will be carried out in relation to this. Therefore, a requirement has been given to support improvement in relation to real time staffing across all professions and ensure clear management oversight.

Evidence and information provided by the NHS board indicates staffing challenges in both the nursing and medical workforce. Staff told inspectors, that it can be difficult to recruit and retain staff due to the remote and rural location of the hospital. Discussion with managers identified that the bank recruitment is not open all year and recruits quarterly which staff believe could be a barrier to applicants. Due to the strong relationships within the community any potential applicants are encouraged to contact lead nurse out with these times if they are looking for a job. Additionally, relocation incentives can be offered within vacancies. During the staffing discussion senior managers reported difficulties recruiting to medical consultant and pharmaceutical posts, with some posts being readvertised several times. Due to the difficulties in recruiting into these posts the board relies heavily on agency staff.

NHS Western Isles currently has three vacancies for senior charge nurse posts. We have asked NHS Western Isles how it is assured that it can provide clinical leadership, oversight and support in the meantime prior to recruitment. NHS Western Isles advised that prior to recruitment the charge nurses within the wards will step up into senior charge nurse position. Each of the charge nurses have previous experience covering the senior charge nurse position. We were told that support will be provided by other senior charge nurses from within the hospital as well as support by senior managers, practice education and human resources teams. Evidence provided by NHS Western Isles also details that lead nurse, hospital manager and associate nurse director will also be on hand daily to provide support and guidance. Additionally, weekly meetings will be held with the lead nurse and associate nurse director to identify any concerns or emerging issues.

The Health and Care (Staffing) (Scotland) Act 2019 commenced on 1 April 2024. It stipulates that NHS boards have a duty to follow the Common Staffing Method (CSM), following a staffing level tool run and requires this to be applied rigorously and consistently. The application of the common staffing method and staffing level tools supports NHS boards to ensure appropriate staffing, the health, wellbeing and safety of patients and the provision of safe and high quality care. During the inspection staff told inspectors that they were aware that staffing level tool runs had been completed. However, staff told us they had not received any feedback from the tool outputs and were not aware of any recommendations that may result in changes to staffing levels or skill mix. From 1 April 2024, NHS boards are required to demonstrate that they are complying with the duties as cited in the legislation. Senior managers told inspectors that they do provide staff with feedback during the tool run, using emails and hospital safety huddles. They also advised they would expect all staff to be aware of the tool runs and be involved in professional judgement and decision making during the tool run. NHS Western Isles reports high confidence in its systems and processes relating to the common staffing method. However, it has been unable to provide us with any written evidence in relation to the processes around the decision making, mechanisms and processes in place to follow the common staffing method. A requirement has been given to support improvement in relation to the consistent application of the common staffing method, including a more robust mechanism for feedback to be provided to staff about the use of the common staffing method, and staffing decisions made as a result.

From evidence provided we identified recurring staffing risks, particularly within one ward within the hospital. There were numerous occasions in which the risk was unable to be downgraded from red. Additionally, within some areas, risks were downgraded from red to amber where the use of student nurses was listed within mitigations. We discussed this at an offsite staffing meeting with senior managers who advised that this is not routine practice and occurs in exceptional circumstances. Senior managers advised they have a close working relationship with the University of Highlands and Islands and that student engagement with practice evaluations is

high. NHS Western Isles advised that student nurses are occasionally used to support staffing mitigations; this practice is not endorsed. However, NHS Western Isles senior managers did advise that where any students are used as mitigation within staffing shortages, this is discussed with the practice education facilitator who would attend the area to support students and staff and discuss the incident to ensure support to all involved. Students on clinical practice placement are in a protected supernumerary capacity and should not be used to mitigate staffing challenges.

Whilst onsite all red areas were mitigated to amber. However, we observed in evidence multiple incidents that were unable to be mitigated. We discussed this with senior managers who advised that the member of staff completing the safe care input is encouraged to insert notes within the huddle template to ensure all aware of the outcomes. Senior managers acknowledged that some staffing discussions take place out with the hospital wide huddle and could be evidenced more effectively within the hospital huddle template and information shared with staff. A requirement has been given to support improvement within this area.

Area of good practice

Domain 4.3	
6	NHS Western Isles has introduced a variety of development opportunities for senior charge nurses.

Requirements

Domain 4.3	
16	NHS Western Isles must ensure that decision making regarding staffing risks and mitigations are open and transparent and aligned with patient acuity.
17	NHS Western Isles must consider skill mix, dependency and complexity of patients to support staff to apply professional judgement when declaring safe to start.
18	NHS Western Isles must ensure a robust system in place consistently to assess and capture real time staffing across all professions to ensure clear management oversight.
19	NHS Western Isles must ensure clear real time staffing data is consistently recorded and communicated and clear escalation processes and any mitigations/inability to mitigate are recorded clearly and accurately.
20	NHS Western Isles must ensure that there are processes in place to support the consistent application of the common staffing method, demonstrating triangulation of quality, safety and workforce data to inform staffing requirements and, where appropriate, service improvement. This includes that the principles of the common staffing method are applied, including having a

robust mechanism for feedback to be provided to staff about the use of the common staffing method, and staffing decisions made as a result.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

Inspectors observed that interactions between staff and patients were positive and respectful. Patients we spoke with described staff as responsive to their needs and spoke highly of the staff and the care provided. Patients also described receiving good communication from both nursing and medical staff. Patients advised that although staff were visibly busy there were no delays to responding to call bells, gaining assistance or administration of medications.

All patients we spoke with, spoke highly of the care received. All patients stated they had received care in a timely manner with no prolonged waits for assistance or treatment. Patients we spoke with advised they would be happy if a loved one had to access care at Western Isles Hospital.

Inspectors found throughout the inpatient wards within Western Isles Hospital that there were no mixed gender bays. Mixed gender bays can have an impact on privacy, dignity and personal choice of patients. Therefore, in cases where it has been clinically justified to mix gender staff should monitor this closely and ensure continuing communication with patients and their representatives. The only mixed gender bay was within the high dependency unit. This is common practice where there is an enhanced care need, enhanced monitoring or a deterioration in patient condition, and they require transfer to areas such as the high dependency unit and intensive care unit.

Within the acute assessment unit there is one multi-bedded area which is often mixed gender. This unit operates 08:00 - 21:00 and patients do not remain overnight. At the time of the inspection patients did not raise any concerns around being cared for in this area.

As previously discussed, NHS Western Isles like many other health boards in Scotland has been required to utilise contingency bed spaces, including placing beds in corridor areas. We did not observe any corridor beds in use in ward areas during this inspection. However, we did observe an empty bed in one ward ready to use if needed. While we did not observe any corridor beds in use, the use of corridor beds will have a negative impact on staff and patient experience, including the privacy and dignity of patients who may not be placed in these beds but need to use the ward corridors. As previously discussed, there is no risk assessment or selection criteria for the placement of patients within this bed. Therefore, an earlier requirement was provided in domain 4.1.

Within the emergency department inspectors raised concerns about two closed circuit television cameras within the corridor. Although the closed circuit television cameras were not within a clinical area, there was potential for footage to be obtained of patients due to the positioning of the contingency bed and the proximity to one of the side rooms. Inspectors discussed the cameras with the senior charge nurse within the department as well as members of the hospital management team. From evidence provided, we can see that in order to access the footage, permissions are required from senior members of the executive team. It was observed in evidence provided that one camera may capture patients within the contingency bed. We discussed this with senior managers to understand if patients and relatives who may be placed within the corridor bed are told about the cameras. However, we were advised there is no formal communication in relation to this. A requirement has been given to support improvement in this area.

Within one ward, inspectors found that there was one shower and no bath for the cohort of 22 patients. This ward often has up to 29 patients due to contingency beds being in use. Inspectors spoke with staff who advised that they rotate which patients are showered each day as not all patients can be showered daily as this is not practically possible. Inspectors raised concerns around a possible lack of dignity for patients due to lack of choice for personal care. Although patients did not have access to showering and bathing facilities, all patients were offered assistance with personal hygiene and where able were provided with a basin to wash at their bedside. When we spoke with hospital managers, they advised plans are in place to upgrade the ward and implement additional showers. However, due to fluctuating COVID-19 numbers and the inability to decant the ward to the neighbouring ward there are no dates for this work as yet. Due to this we are not assured that all patients will have access to showering facilities. A requirement has been given to support improvement in this area.

Areas of good practice

Domain 6	
7	All observed interactions were professional, friendly and respectful.
8	Patients speak highly of the care received.

Requirements

Domain 6	
21	NHS Western Isles must ensure patient dignity is maintained at all times. This includes but is not limited to access to shower facilities for all patients.
22	NHS Western Isles must ensure safe and effective policies and procedures are in place for all CCTV cameras in use. CCTV cameras must be operated in line with national regulation, guidance and local policy and staff are aware of and apply correct procedures.

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 2023)
- Ageing and frailty standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland - Draft standards out for comment April 2024)
- Corridor care: unsafe, undignified, unacceptable (Royal College of Nursing, June 2024)
- Food, fluid and nutritional care standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland, November 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)

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