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Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Lorn and Islands Hospital

NHS Highland

28–29 October 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

Lorn and Islands Hospital is a remote and rural general hospital located on the southern outskirts of Oban. It has 46 acute beds and six day-case beds, plus a day case MacMillan unit. The hospital forms a hub for both acute and community services, housing the full range of facilities expected in a rural general hospital including an emergency department and inpatient surgical and medical wards. The hospital caters for palliative care and elderly patients as well as providing a midwifery service and a multi-purpose day hospital.

Argyll and Bute Integration Joint Board is the public body that has strategic oversight and direction of integrated services across Argyll and Bute. The Argyll and Bute area is divided into four localities. This includes Oban, Lorn and the Isles which incorporates Lorn and Islands Hospital. Delivery of services based within Lorn and Islands Rural General Hospital is delegated by NHS Highland to the Integration Joint Board of Argyll and Bute Health and Social Care Partnership, whilst overall clinical governance remains the responsibility of NHS Highland. The Integration Joint Board is the governance board of the Argyll and Bute Health and Social Care Partnership.

Lorn and Islands Hospital also work closely with NHS Greater Glasgow and Clyde health board, from whom Argyll and Bute Health and Social Care Partnership commission acute and specialist services for emergency, elective and outpatient services.

About this inspection

We carried out an unannounced inspection to Lorn and Islands Hospital, NHS Highland on Monday 28 and Tuesday 29 October 2024 using our safe delivery of care inspection methodology. In parallel to this inspection, we also carried out a safe delivery of care inspection at Raigmore Hospital Inverness.

During our inspection of Lorn and Islands Hospital we inspected the following areas:

- emergency department
- ward A
- ward B
- ward I

During our inspection, we:

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

As part of our inspection, we also asked NHS Highland 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 Highland and Argyll and Bute Health and Social Care Partnership during December and January 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 Lorn and Islands Hospital we inspected at the time of this inspection.

We would like to thank NHS Highland and in particular all staff at Lorn and Islands 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 deliver care with patients being complementary about their care and the staff providing it.

We observed good teamwork with all areas inspected calm and well led. All patients in the emergency department were in designated cubicles and inspectors did not observe any delays in ambulance turnaround times.

All patients we spoke with were complimentary about their care and the staff providing it and described compassionate and responsive care.

Domestic staff were visible throughout the hospital and the hospital environment including communal areas were clean and well maintained. All areas inspected were tidy and uncluttered.

Hospital managers advised that the remote and rural location of the hospital can add challenges to recruitment of staff including availability and affordability of accommodation.

There is no onsite mental health unit within Lorn and Islands Hospital. Staff advised inspectors that patients who are experiencing acute mental health crisis are often admitted to the medical and surgical wards within Lorn and Islands Hospital whilst awaiting mental health assessments or transfer to an available mental health unit. We raised concerns with NHS Highland relating to lack of appropriate nursing staff training in caring for patients who are experiencing acute mental health conditions.

Other areas for improvement have been identified at Lorn and Islands Hospital. These include the completion of patient documentation and safe storage of cleaning products.

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

This inspection resulted in seven areas of good practice, one recommendation and 14 requirements.

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

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

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

Areas of good practice

The unannounced inspection to Lorn and Islands Hospital resulted in seven areas of good practice.

Domain 1	
1	100% of nursing staff in the emergency department have completed paediatric immediate life support training (see page 19).

Domain 2	
2	Staff described supportive and visible hospital managers at local level (see page 21).

Domain 4.1	
3	Patients were complimentary about their care and the staff providing it (see page 26).
4	Domestic staff were visible throughout the hospital with all areas visited tidy and cleaned to a high standard (see page 26).
5	Medications were stored securely in all areas inspected (see page 26).

Domain 4.3	
6	There are a number of initiatives in place to improve the challenges of recruiting to a remote and rural area (see page 30).

Domain 6	
7	Staff were working hard to provide compassionate and responsive care. Staff told us of the support of the dementia team to support individual patient centred care (see page 31).

Recommendation

The unannounced inspection to Lorn and Islands Hospital resulted in one recommendation.

Domain 4.1	
1	NHS Highland should ensure that patients are assisted with hand hygiene prior to mealtimes where required (see page 26).

Requirements

The unannounced inspection to Lorn and Islands Hospital resulted in 14 requirements.

Domain 1	
1	NHS Highland must ensure that all patients have access to a call bell or a means to contact staff in an emergency and that all call bells are within easy reach of patients (see page 19). This will support compliance with: Health and Social Care Standards (2017) criteria 1.12, 1.14, 3.17, 3.21 and 5.18; Quality Assurance System: Quality Assurance Framework (2022) criteria 4.1 and 6.2 and relevant codes of practice of regulated healthcare professions.
2	NHS Highland must ensure a written process/pathway is in place to ensure continuity of care and staff support when patients require transfer to specialist sites (see page 19). This will support compliance with Quality Assurance Framework (2022) Indicator 4.1.
3	NHS Highland must ensure there is one member of staff on duty in the emergency department at all times who has advanced paediatric life support training or equivalent (see page 19). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and The Royal College of Paediatrics and Child Health standards 'Facing the Future: Standards for children in emergency care settings 2018.

4	NHS Highland must ensure that risk assessments and mitigations are completed fully to identify patients who may be at risk of harm to themselves or others (see page 19). This will support compliance with Quality Assurance Framework (2022) Indicator 4.1 and Health and Social Care Standards (2017) Criteria 1.24.
5	NHS Highland must ensure that staff are suitably qualified and competent to safely carry out their role including where relevant: public protection training, mental health training including relevant legislation and the management of violence and aggression prevention training (including breakaway and restraint) (see page 19). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 the Nursing and Midwifery The Code: sections 9.4 and 13.5 and NHS Public Protection Accountability and Assurance Framework (2022).
6	NHS Highland must ensure environmental ligature risks are assessed, and relevant staff are trained to recognise and manage ligature risk (see page 19). This will support compliance with: Health and Social Care Standards (2017) Criterion 1.24 and Quality Assurance Framework (2022) Indicator 2.6.and 4.1.

Domain 2	
7	NHS Highland must provide support and 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 22). This will support compliance with: Quality Assurance System: Quality Assurance Framework (2022) Criteria 2.6 and learning from adverse events through reporting and review: A national framework for Scotland (2019).
8	NHS Highland must ensure effective and appropriate governance approval and oversight of policies and procedures are in place (see page 22). 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 Highland must ensure that all patient documentation is accurately and consistently completed. This includes Adults with Incapacity Section 47 documents and do not attempt cardiopulmonary resuscitation documentation (see page 27). This will support compliance with: Quality Assurance System (2022) Criterion 4.1 and relevant codes of practice of regulated healthcare professions.

10	NHS Highland must ensure all staff comply with the appropriate wearing of jewellery (see page 27). This will support compliance with: NHS Scotland National Uniform Policy, Dress Code and Laundering Policy 2018.
11	NHS Highland must ensure that all staff comply with required transmission-based precautions (see page 27). This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022).
12	NHS Highland must ensure all hazardous cleaning products are securely stored (see page 27). This will support compliance with the Control of Substances Hazardous to Health (COSHH) Regulations 2002).

Domain 4.3	
13	NHS Highland must ensure that hospital safety huddles consider decision making regarding real time staffing risks and mitigations and that these are documented and aligned with patient acuity and dependency to support skill mix and staffing (see page 30). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019 and Quality Assurance System (2022) Criterion 4.1
14	NHS Highland must ensure that there are processes in place to support the consistent application of the common staffing method. This includes 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 30). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

Despite pressures on hospital capacity the emergency department was operating within capacity with all patients being cared for in designated areas and we did not observe any delays in ambulance turnaround times.

Lorn and Islands Hospital has acute facilities including an accident and emergency, medical and surgical wards, operating theatres and maternity unit. Surgical sub specialities such as ophthalmology and orthopaedics are provided by consultant medical staff from NHS Greater Glasgow and Clyde.

At the time of this inspection Lorn and Islands Hospital had a number of contingency beds in use. These beds are reopened bed areas that had been closed during the COVID-19 pandemic to enable required space between beds.

The national target for accident and emergency waiting times means that 95% of patients should wait no longer than four hours from arrival to the emergency department before admission, discharge or transfer for other emergency treatment. Across NHS Scotland for the week ending 3 November 2024, 63.9 % patients were seen within the four hour target with 92.2% of patients seen within the four hour target at Lorn and Islands Hospital.

During our onsite inspection we did not observe any delays in patients being transferred from ambulances into the emergency department and all patients were being cared for in designated cubicles. There was a 60 minute wait for assessment by a clinician on the first day of our inspection, with the longest wait for transfer to an inpatient bed being four hours on the morning of the second day of inspection.

Scottish Government emergency signposting guidance seeks to ensure patients receive care in the most appropriate setting while helping to improve waiting times and delays in emergency departments and acute admission units. Further information can be found here. Lorn and Islands Hospital does not have any acute admission units and all patients who require to be admitted to the hospital are transferred directly from the emergency department to an inpatient ward. All referrals from general practitioners are assessed in the emergency department.

Lorn and Islands Hospital has a hospital at home team which has been in place for two years. Evidence provided includes the Primary Care Referrals to Lorn and Islands Hospital Patient Pathway. The pathway includes the flow chart to be followed by general practitioners if they assess that a patient requires hospital level assessment. This includes telephone referral to an emergency department clinician. On attendance

to the emergency department the patient is assessed and, if clinically suitable, is referred to the hospital at home service.

The hospital at home service is available Monday–Friday between 08:00–18:30 and are currently recruiting to enable a seven day service. Hospital at home staff include advanced clinical practitioners. Advanced clinical practitioners are healthcare professionals who have developed the skills and knowledge to allow them to take on expanded roles and scope of practice caring for patients.

The role of the team includes admission avoidance and supported discharge. General practitioners and Scottish Ambulance staff can contact the hospital at home team to discuss if patients can be looked after at home by the team to prevent unnecessary admission to hospital. Staff also advised inspectors of new pathways whereby care homes can access the hospital at home service. The service includes pharmacist input to enable medication reconciliation. The hospital at home team will link in with the wards and emergency department to see if any patients are suitable for support for discharge.

Evidence provided includes the exclusion criteria for the service which includes but is not exhaustive of, acute chest pain, acute stroke, surgical problems and age under 18. Referral criteria specifies that patients must be medically stable and duty consultants must agree to referral. The hospital at home team has a bay within one of the wards in Lorn and Island Hospital where patients can attend for consultant medical review or treatments such as blood transfusions. Clinicians from the team can also provide comprehensive assessments within care homes and patients' own homes including delirium assessments. Delirium is the sudden onset of confusion and can be caused by medication and illness such as infection and electrolyte imbalance.

Patients who self-present to the emergency department at Lorn and Islands Hospital book in at reception in the main entrance of the hospital and their emergency department patient record is then automatically printed off in the emergency department. Patients are then seated in the waiting area prior to triage.

The waiting area for the emergency department is based in a corridor between the main entrance and emergency department and therefore cannot easily be seen by staff. Whilst there is closed circuit television monitoring of the waiting area, patients are not visible to reception or emergency department staff and there are no available call bells or emergency buzzers within the waiting area. A requirement has been given to support improvement in this area.

Inspectors asked staff of the processes in place if a patient booked into reception with a condition that may require immediate assessment/treatment such as cardiac problems. Staff advised that in this instance reception staff will ring through to alert nursing staff. During our onsite inspection we observed the process of reception staff notifying nursing staff that there were patients waiting for triage and that staff were responsive in calling the patients through for triage.

As part of this inspection, we asked NHS Highland to provide evidence of any incidents reported by staff in relation to patient safety for the three months prior to this inspection. We can see from these that none were submitted in relation to delayed triage times or relating to patients in the waiting area. However, we did see two incident reports submitted as there was no available reception staff overnight. We discussed this with hospital managers who advised that if unable to cover planned or unplanned gaps on the reception staff rota that portering staff would be requested to provide cover. If gaps were due to last minute absence and unable to be covered by portering staff, emergency department staff would cover reception. Security cameras are available at the main entrance which can be viewed at reception and in the emergency department to enable oversight of people attending overnight. Hospital managers also advised that the emergency department only has an average of five patient attendances overnight.

Lorn and Islands Hospital emergency department consists of three individual cubicles, a two bedded resuscitation area and a curtained cubicle within the main area. Staff advised that whilst delays in transferring patients from ambulances were rare, if there was no capacity within the department, patients would remain within the ambulance. We asked hospital managers what processes were in place if there is a delay in transferring patients from ambulances due to lack of available space within the department. We were advised that pre-hospital alerts and the use of the ambulance arrivals screen enable staff to prepare for ambulance arrivals. Pre-hospital alerts are when the Scottish Ambulance Service contact the emergency department to notify that they are bringing a patient in who will require immediate assessment due to their clinical condition. This enables staff to prepare and allocate resources to treat the patient on arrival.

Hospital managers also advised that delays in ambulance crews being able to transfer patients straight into the department were unusual. Available national data shows that for the week of the 30 September 2024, the median ambulance turnaround time at Lorn and Islands Hospital was 00:20:57. The national average for the same time was 00:48:44. We did not see any incident reports submitted in the three months prior to our inspection relating to delays in ambulance turnaround times.

There are no inpatient paediatric services within Lorn and Islands Hospital. Paediatric patients that require admission are transferred to the Royal Hospital for Children, NHS Greater Glasgow and Clyde. Staff told inspectors that there could be delays in the transfer of patients to NHS Greater Glasgow and Clyde if the transfer is not an immediate emergency due to distance of journey and available ambulances. Staff also told us that they work closely with ScotSTAR for emergency transfers and ScotSTAR staff were providing scenario training to Lorn and Islands staff during our onsite inspection. ScotSTAR is a national service for safe and effective transport and retrieval of critically ill children and adults throughout Scotland. There is also no intensive care provision for adults within Lorn and Islands Hospital and all adults who require intensive care provision will be transferred to NHS Greater Glasgow and Clyde. We

asked senior managers what processes are in place to support staff when patients require transfer to specialist sites. Hospital managers advised that there is no specific standard operating procedure or protocol in place. However, there would be discussion with the receiving doctor at the relevant speciality, including paediatrics and that support would be provided by the on-call consultant anaesthetist. Whilst we did not see any incident reports submitted in evidence provided relating to the transfer of paediatric or adult patients, a requirement has been given to support improvement in this area.

The majority of nursing staff within the emergency department are trained to provide adult care. 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 advanced paediatric life support (or equivalent training).

We asked NHS Highland to provide us with the levels of nursing staff who have received additional training in caring for paediatric patients, including recognising a deteriorating child and paediatric life support. We can see from this that 100% of registered nursing staff in the emergency department have completed paediatric immediate life support. This should be noted as an area of good practice as we have observed significantly lower compliance in other hospital inspections. The course is developed by the Resuscitation Council UK for health professionals who may have to manage and treat paediatric patients in an emergency. Medical and nursing staff within the emergency department also attend the structured critical airway management course which teaches the management of paediatric airways. We can see in evidence that 100% of nursing staff and 80% of medical staff, including anaesthetists have attended this training. Yearly trauma training is also provided which include scenarios for both paediatric and adult patients. Hospital managers advised that two of the medical staff and the practice educator for the emergency department have advanced paediatric life support instructor status. Hospital managers advised that general practitioners would provide support in reviewing paediatric patients out of hours if required.

The Royal College of Paediatrics and Child Health standards 'Facing the Future: Standards for children in emergency care settings' also documents that every emergency department treating children must have one member of staff on duty at all times who has advanced paediatric life support (or equivalent training). Evidence provided by NHS Highland documents that there is not always a member of staff on duty in the emergency department with advanced paediatric life support (or equivalent training). Hospital managers advised that advice and support can be obtained from the emergency medical retrieval service, Royal Hospital Sick Children in Glasgow and the on call anaesthetic consultant. Hospital managers also confirmed that all on call anaesthetists are trained in advanced paediatric life support. However, the on-call anaesthetist is not based in the hospital overnight and would be required to be

called into the hospital. A requirement has been given to support improvement in this area.

Whilst we did not see any incident reports submitted in evidence provided relating to the care of paediatric patients, we did see an incident report where staff were unable to contact the on-call anaesthetist due to a mobile phone network fault. The submitted incident report documents the improvement actions taken following the incident as including a record of accommodation details for locum medical staff to be kept at main reception to enable contact via land line.

As previously discussed, all patients within the emergency department were being nursed in cubicles and we did not observe any obstruction to fire exits. Whilst contingency beds were in use on the wards these were bed spaces which had been closed during the COVID-19 pandemic to ensure physical distancing. These beds were in designated bed spaces and as such were not obstructing corridors or fire exit routes. Staff we spoke with were able to show inspectors fire evacuation plans. Evidence provided by NHS Highland includes two examples of a completed monthly fire check and fire evacuation plan. The monthly fire check is completed by a senior member of staff and includes, but is not exhaustive of, ensuring fire escapes routes are not obstructed, fire doors are not wedged open and fire extinguishers are serviced annually. One of the questions on the checklist is “are medical gas cylinders securely stored and rooms containing cylinders provided with signage?”. We can see from the evidence provided that in one area it has been documented that there is no signage on the door for three consecutive months. We asked senior managers what processes are in place to review the checklists and how lessons learned were shared and improvements actioned. We were advised that fire risk assessments are reviewed by the department lead, team lead and senior charge nurse for the area and fire risk assessments are reviewed at the clinical care and governance forum. A fire risk assessment of the hospital was undertaken in December 2024 with report pending. We were also provided with evidence that there is now appropriate signage on the cupboard door that had been highlighted in the three risk assessments.

Emergency department staff informed inspectors that Lorn and Islands Hospital emergency department is a dedicated place of safety. A place of safety is used by the police when they believe a person is experiencing a mental health crisis and in need of immediate care and treatment. The room that is used as the place of safety room within the department is through a set of doors and in a corridor linking to another department in the hospital which is not easily visible from the emergency department. Staff advised that if police do not stay with patients that a member of nursing staff would be required to stay with the patient due to the room location. Staff also told inspectors that whilst they would request agency or bank mental health nurses to provide support, that these were not always available and, in these instances, patients may be moved to a cubicle in the main emergency department that is easily visible.

Evidence provided includes the operational policy for Lorn and Islands Hospital, place of safety room. This documents that care must be provided by staff trained in the management of violence and aggression, the Mental Health (Scotland) Act 2003, updated 2015, resuscitation, medication (including sedation policy) and Sainsbury level 1 risk Assessment. The operational policy for the place of safety states that the care needs and safety of the patient remains the responsibility of the emergency department until the time of transfer is appropriate. The policy further states that all patients in the place of safety room should have a Sainsbury level 1 risk assessment carried out. The Sainsbury risk assessment tool is used to assess risk indicators for suicide, neglect, violence and aggression and other risk such as risk of absconding. There is a section for summary of assessment and risk management plan.

We asked hospital managers for any environmental risk assessments that had been completed. Evidence returned included the general risk assessment form for the place of safety room within the emergency department. This was completed in November 2021 and documents a description of hazards, including but not exhaustive of, the inability to supervise patients experiencing a mental health crisis due to the location of the room and lack of available staffing, particularly at night when there are only two nurses on duty. The risk assessment also highlights that the place of safety room is not completely ligature free as it has window blinds in situ. Hospital managers advised that whilst the blinds are anti-ligature and, will detach from the window, that NHS Highland's health and safety officer had advised that they could still pose a ligature risk and are therefore documented in the risk assessment. Documented control measures for the place of safety room include available emergency buzzers and personal safety alarms for staff. We were also advised that if patients were moved from the place of safety room into a main cubicle in the emergency department that items which pose an immediate risk to patients or staff are removed. Ligature risk assessments are discussed later in this report.

If a patient is assessed as potential risk to self or others, support is requested via the police and mental health services. Emergency department staff informed inspectors that they were able to request supplementary mental health nursing staff to support the use of the place of safety room. However, these were not always available. Hospital managers advised that if mental health staff are not available, a member of the emergency department who is trained in managing violence and aggression will care for the patient. We were also advised that if the patient was displaying behaviour that was deemed a risk to staff that the police would provide support. During our onsite inspection staff described the police as being responsive and supportive.

Inspectors were told by staff that if there is a delay in patients awaiting assessment by the mental health crisis team, psychiatrist or transfer to a mental health inpatient area that they will be transferred from the emergency department to one of the wards within Lorn and Islands Hospital. Staff also highlighted that the mental health crisis team was only available to assess patients between the hours of 10:00–18:00.

Hospital managers advised that the longest wait for an available mental health bed has been five days. We were also told that if there is a delay in patients being transferred to a mental health unit that support will be provided by the mental health crisis team, local community psychiatric nurse and via telephone or video call with consultant psychiatrist. Mental health trained nurses will also be requested to support ward staff via the nurse bank or agency.

We held a virtual discussion with NHS Highland relating to the care pathway for patients who are awaiting mental health assessment or transfer to a mental health unit. During this discussion hospital managers advised that as a remote and rural site, there are additional challenges in accessing mental health support. However, support and advice is available from the psychiatric services at Argyll and Bute mental health unit. Hospital managers noted a possible disconnect between available support and staff accessing it and advised that available support and how to access it would be reiterated to staff. Hospital managers also recognised the need to listen and act on staff concerns.

Hospital managers advised that whilst there is no specific standard operating procedure in relation to the admission of patients experiencing a mental health crisis to the general wards, each patient is assessed on an individual basis to decide the most suitable placement. This assessment takes into consideration bed availability and staffing levels. Medical staff in the emergency department will complete the Sainsbury risk assessment and this can be discussed with a mental health specialist if required. We reviewed available care records of patients during our onsite inspection and, whilst we observed a patients Sainsbury risk assessment it did not appear to be fully completed. It had no entry in the summary of assessment or corresponding risk management plan. Staff advised inspectors that a Sainsbury risk assessment should be completed for all patients who may be experiencing a mental health crisis who are at risk of harming themselves or others but that these were not always completed. A requirement has been given to support improvement in this area.

The Health and Care (staffing) (Scotland) Act 2019 (the Act), came into effect on the 1 April 2024.The aim of the Act is to provide a statutory basis for the provision of appropriate staffing in health and care service settings. Thereby, enabling safe and high-quality care and improved outcomes for service users. The Act requires that all staff are suitably qualified and competent in their role.

Nursing staff on the wards expressed concern that they did not have suitable training to ensure care is delivered appropriately when caring for patients who are experiencing an acute mental health crisis. Staff also highlighted the impact of caring for patients with acute mental health conditions within general wards in relation to episodes of violence and aggression towards staff and increased patient acuity and dependency. Inspectors were told that staff were supported to request supplementary mental health nursing staff but these were often not available. Escalation of staffing concerns are discussed later in this report.

We can see in further evidence provided that additional mental health training for staff within the hospital is low. With only two medical staff and three nursing staff in the emergency department receiving training in 2023. Hospital managers advised that there is an escalation process in place via hospital safety huddles, bed management meetings and clinical handovers where staff can highlight any concerns.

We asked hospital managers if there is an entry on NHS Highland's risk register in relation to patients waiting for mental health beds being cared for on the general wards and a lack of available mental health specialist nurse cover. We were advised that whilst there is no entry in the risk register relating specifically to this, there is a generic risk relating to specialist staff not always being available which would encompass mental health nurses. A risk register is an important part of healthcare risk management and identifies, assesses and documents management or mitigation of any risks identified by the NHS board.

Evidence provided by NHS Highland includes staff training compliance for violence and aggression prevention training throughout the hospital. We were provided with training figures for both theory and breakaway training. Breakaway training teaches staff how to disengage from potentially harmful situations. We can see from this evidence that training compliance varies across the hospital site. For example, only 41.66% of staff in the emergency department have completed the theory training. However, in one ward area, it has been completed by 69.23% of staff. Breakaway training compliance varied from 66.66% in the emergency department to 88.46% in one of the ward areas.

We can see in a submitted incident report that action taken after an episode of aggression by a patient towards staff, that staff were given the opportunity to debrief after the incident. We were told by hospital managers that immediate debriefs are offered to staff following any difficult or challenging situations. The senior charge nurse for each area is supported by senior managers to ensure the wellbeing of the staff. Staff we spoke with told inspectors that they felt well supported by hospital managers. Health and wellbeing support for staff is discussed in further detail later in this report.

During our onsite inspection we were able to observe the hospital wide safety huddle which included discussion of a patient who required one to one nursing care. Patients may require one to one nursing care for a number of reasons, including risk of falls, risk of harm to themselves or others, or risk of absconding. Inspectors also observed a ward shift safety brief template which enabled staff to highlight and share risks and concerns. Hospital managers advised that since our onsite inspection a resource folder and standard operating procedure for 'assessment, care and support for patients experiencing a mental health crisis or presenting with significant stress or distress who require admission to a general ward' has been developed. We can see in evidence provided that the resource folder includes but is not exhaustive of, useful contact numbers, increased levels of care policy and the standard operating procedure. The

increased levels of care policy was due for review in 2019. However, the policy is only now currently undergoing review. The standard operating procedure documents that all patients should be triaged in the emergency department and have Sainsbury risk assessment and be admitted to the most appropriate ward and bed. It is also documented that staff should have opportunity for formal debrief.

In August 2024 the Health and Safety Executive issued an improvement notice to Lorn and Islands Hospital in relation to reducing possible ligature risk in areas where patients who may have suicidal ideation are cared for.

Whilst this inspection is separate to and not related to the Health and Safety Executive inspection, during our onsite inspection staff raised ongoing concerns relating to its findings and specifically the care of patients with mental health conditions on the general wards. Returned evidence from NHS Highland includes the health and safety policy for the management of suicide and ligatures. This documents that the scope of the policy includes all areas of NHS Highland where patients/service users are accessing treatment or care. The policy also states that all areas must assess the level of risk regarding the potential of patient suicide and, if believed to be reasonably foreseeable, then a risk assessment should be carried out using the site risk assessment document. Local procedure should be completed which details the actions to be taken to ensure patient safety and that this will include, for example, all accident and emergency departments and all inpatient settings. The health and safety policy for the management of suicide and ligatures is documented as having a yearly review cycle. However, it was last reviewed in February 2022. The management and oversight of pathways and policies are discussed further later in this report.

During our onsite inspection we were told by a member of staff that whilst they were aware of the environmental ligature risk assessment, they had not received any training in completing this. Staff in other areas were unaware of either the availability of the risk assessment, or if one had been completed. We asked hospital managers if staff have received any additional training in completing ligature risk assessments. We were advised that staff on the wards and emergency department have not been formally trained in how to complete ligature risk assessments. A requirement has been given to support improvement in this area.

We raised these concerns with senior managers and we were provided with evidence of a walk around of the emergency department and ward areas of Lorn and Island Hospital on the 11 November 2024. This was undertaken by various members of the hospital management team, with representatives from health and safety, mental health and estates department. Opinions were also sought from the senior charge nurses of the areas. The purpose of the walkaround was to assess the environment in respect to providing safe care for patients who may be experiencing suicidal ideation.

Agreed actions from the walkaround includes an environmental ligature audit for specified side rooms, bathrooms and bays. It is also documented that ligature cutters

have been placed on resuscitation trolleys within the hospital. During our onsite inspection staff confirmed that ligature cutters were available. Further actions include a review of how violence and aggression training is delivered as the senior charge nurses felt it could be delivered in a better way to meet the needs of the staff. Actions also include the need to review how specialist mental health services provide in reach services to Lorn and Islands Hospital. It was highlighted that there needs to be a more robust process for obtaining mental health trained staff when required.

Evidence provided by NHS Highland documents that the environmental audits will be commenced at the end of January 2025 and will be undertaken by staff who have received appropriate training. NHS Highland will also contact other NHS boards to understand their approaches to ligature audits and risk assessments in acute general settings.

Area of good practice

Domain 1	
1	100% of nursing staff in the emergency department have completed paediatric immediate life support training.

Requirements

Domain 1	
1	NHS Highland must ensure that all patients have access to a call bell or a means to contact staff in an emergency and that all call bells are within easy reach of patients.
2	NHS Highland must ensure a written process/pathway is in place to ensure continuity of care and staff support when patients require transfer to specialist sites.
3	NHS Highland must ensure there is one member of staff on duty in the emergency department at all times who has advanced paediatric life support training or equivalent.
4	NHS Highland must ensure that risk assessments and mitigations are completed fully to identify patients who may be at risk of harm to themselves or others.
5	NHS Highland must ensure that staff are suitably qualified and competent to safely carry out their role including where relevant: public protection training, mental health training including relevant legislation and the management of violence and aggression prevention training (including breakaway and restraint).
6	NHS Highland must ensure environmental ligature risks are assessed, and relevant staff are trained to recognise and manage ligature risk.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

All areas inspectors visited were calm and well led. The majority of staff we spoke with described feeling supported by the Lorn and Island Hospital managers. However, inspectors were also told by some staff that more senior board-wide managers were not visible.

Whilst the majority of staff described a supportive culture from Lorn and Islands Hospital managers, we were told that senior nursing staff from the wider NHS board lacked visibility in the hospital.

Inspectors were able to speak with a member of the medical team in the emergency department who told us that they could access support when needed. Nursing staff in the department also described hospital managers as supportive and available.

Despite the hospital being at increased capacity with the utilisation of additional beds, areas we visited were calm and well led. We observed a supportive culture at ward level with staff openly supporting each other. However, some staff expressed frustration at the ongoing use of additional beds.

The learning from adverse events national framework indicates that all adverse incidents should be reviewed, immediate actions taken, and lessons learned shared. 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.

Evidence provided, documents that trends and actions from incident reports are discussed at the quarterly Lorn and Islands Hospital clinical care and governance meetings. Incident reports are also discussed at the two-weekly quality, patient and safety meetings which assess if a significant adverse event review, duty of candor or case conference is required. This meeting also monitors progress against highlighted actions. We can see in the minutes of these meetings that updates are documented in relation to action points. However, we can see that a number of incident reports submitted as evidence appear to have been in the holding area awaiting review for three weeks. We asked hospital managers what processes are in place for oversight of incidents when they are initially submitted. We were advised that hospital managers and senior charge nurses for the area involved receive e-mail alerts of all newly submitted incident reports. The quality, patient and safety meeting review all open incidents bi-weekly to provide oversight. We were also advised that senior staff who are responsible for the management of the incident review will receive reminders of incidents that are still open.

In one area we were told of an incident that had resulted in a serious adverse event review. We asked hospital managers what support had been provided to the staff following the incident. They advised that there had been a debrief with staff involved and senior hospital managers. Other support included occupational health and specialist clinical psychology support. All staff were also signposted to additional support from NHS Highland staff health and wellbeing services.

We also asked hospital managers how lessons learned from incident reports were shared with staff. We were advised that this was via team brief, heads of department staff meetings and individual ward/department meetings. However, whilst staff informed us they felt supported to raise concerns, some staff we spoke with felt that their concerns were not always responded to, and they did not always receive feedback to incident reports. A requirement has been given to support improvement in this area.

We asked hospital managers what health and wellbeing support was available to staff. Evidence provided includes a number of initiatives including NHS Highland employee assistance programme. This provides access to counselling which staff can access in confidence. This can be accessed via a helpline number or the wellbeing hub. Staff can also gain debt and finance advice as well as guidance to improve sleep, diet and exercise. NHS Highland has a staff health and wellbeing website which includes links to NHS Highland's independent 'speak up' guardian. This service provides staff with the opportunity to independently discuss concerns relating to patient care and safety and any work grievances. The site also provides information for staff relating to how to manage compassion fatigue. Compassion fatigue is a physical or mental exhaustion that occurs in people who care for others. Hospital managers advised that there is a weekly team brief co-ordinated by the hospital librarian which includes a reminder to staff of available health and wellbeing support. This is e-mailed to staff and printed and placed on staff notice boards within the hospital and in the staff library.

Evidence provided by NHS Highland includes several guidelines and risk assessments which are overdue their review date. This includes NHS Highland's management of suicides and ligatures, increased levels of care policy for general settings and, the Sainsbury centre clinical risk management tool: operational guidelines.

We raised this with hospital managers who advised that policies and guidelines are reviewed by the quality patient safety group with the two policies under mental health partnership currently under review. A requirement has been given to support improvement in this area.

Area of good practice

Domain 2	
2	Staff described supportive and visible hospital managers at local level.

Requirements

Domain 2	
7	NHS Highland must provide support and 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.
8	NHS Highland 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 spoke highly of the care they received and the responsiveness of the staff providing it. Despite all areas being busy we observed caring and respectful interactions between patients' visitors and staff. However, we observed that some documentation was not fully completed, and cleaning products were not stored securely.

We observed that all areas were calm and well organised with all patients complementary about their care and the staff providing it. Patients looked well cared for, comfortable and call bells were answered promptly. However, whilst we observed that patients had access to call bells, these were not always left within easy reach of patients. During our corresponding inspection at Raigmore Hospital on Monday 28 to Wednesday 30 October, we also observed that patients did not always have call bells within easy reach. A requirement has been given in both inspection reports to support improvement in this area.

We observed a supportive culture at ward level with good teamwork evident. Whilst additional beds were in use these were established bed spaces which had been closed during the COVID-19 pandemic to ensure physical distancing. These beds had available privacy screens, call bells and access to electrical points. However, staff expressed to inspectors their frustration regarding the ongoing use of additional beds and increased acuity and dependency of patients. We asked hospital managers what staffing provision is in place when additional beds are utilised. They advised that additional supplementary staff are requested, including agency staff or regular staff working additional hours. If supplementary staff are unavailable, support will be provided from other areas where able, including community teams, hospital at home and allied health professionals. Staffing concerns are escalated at the hospital and NHS board wide safety huddles as well as to the out of hours senior manager. There is also a senior nurse on duty 24/7 to provide support. We did not observe any patient safety incident reports in regard to additional beds in evidence provided.

Hospital managers advised that if additional beds are in place there are increased cleaning schedules, including public areas such as, reception. Increased cleaning of public areas also takes place if there is a rise in respiratory infections within the community. Hospital managers also confirmed that there had been no infection control outbreaks related to the use of additional beds.

Hospital managers advised that incident report trends are discussed at local clinical care and governance meetings and, that these have seen an increase in submitted reports in relation to inpatient falls. Evidence provided includes the terms of reference for the Argyll and Bute inpatient falls meetings. The terms of reference documents that the purpose of the meetings includes monitoring all ward-based falls offering quality improvement support and providing governance and oversight to monitor progress. Updates on falls will be reported monthly to the NHS Highland falls steering group. The inpatient falls policy has been updated and is awaiting ratification and a new post-falls documentation bundle is being trialled in North Highland. NHS Highland increased levels of care policy provides direction and guidance on the care and assessment of patients who may require increased levels of care due to a risk of harm from falls. As previously discussed, the policy is currently undergoing review.

During our onsite inspection we observed that whilst falls risk assessments were mainly complete, there was not always a clear plan on how to mitigate risk if patients were assessed as being at high risk of falls. Staff told inspectors where able, patients who were identified as being at significant risk of falling, would be placed in bed area nearer to the nurses station to enable closer observation. Patient care documentation is discussed further later in this report.

We had the opportunity to observe a ward mealtime which was well coordinated with meals distributed in a timely manner and patients receiving assistance when required. Patients told us that the food was of a good quality and staff advised as the meals are made on site that any issues can be rectified quickly.

Medications were stored securely in all areas we visited.

As previously discussed, staff raised concerns that they did not have the skills to ensure care is delivered appropriately for patients who are admitted to the medical or surgical ward experiencing acute mental health crisis.

The Mental Welfare Commission for Scotland ‘good practice guide, rights, risks and limits to freedom (2021)’ documents that medication as restraint includes the use of sedative medication for purely symptomatic treatment of restlessness or other disturbed behaviour. The guide also highlights that patient restraint should be seen as a last resort, when there is absolutely no alternative.

Incident reports submitted as evidence by NHS Highland from 2024, include several relating to the administration of intramuscular sedation for patients who have become distressed and may be at risk of harming themselves or others.

NHS Highland provided us with the link to the rapid tranquilisation policy which includes algorithms outlining the protocol for rapid tranquilisation in three different patient age groups. These include general adult (18–65 years), older adult (typically, over 65 years) and young people (12–17 years). It is documented in the policy that rapid tranquilisation should be a last resort option. Guidance includes optimising regular medication and use of non-pharmacological interventions such as, using techniques for calming and distraction. We can see that the policy is overdue it's review date with a planned review date of the end of March 2025.

We asked hospital managers how they assured themselves that the use of medication as restraint was the most appropriate treatment for the patients discussed in the submitted incident reports. NHS Highland actioned a review of the incidents and provided us with an update on their findings. We can see from this that patient records were reviewed by a consultant physician to review patient management before, during and after incidents. The data was reviewed by hospital managers including senior medical and nursing staff.

The scope of the review included episodes where NHS Highlands rapid tranquilisation policy had been required. Findings of the review include good documentation, discussion with consultant psychiatrist/old age psychiatrist either pre or post use of rapid sedation and compliance with the rapid tranquilisation policy. It is also highlighted that de-escalation techniques were tried prior to sedation such as changing patient placement in the ward as well as oral medication being offered initially. these findings are due to be included at the next Lorn and Islands Hospital clinical care and governance meeting.

It is documented in an incident report submitted as evidence, that a patient required physical restraint to prevent them harming themselves and others. Physical restraint training supports staff in how to apply restraint techniques safely without causing unnecessary harm or distress to patients. We can see in evidence provided, that staff compliance with restraint training varies from 12.5 % to 40.6% across wards and departments. We asked hospital managers who would provide physical restraint if it was required if staff on the ward area had not completed physical restraint training. We were advised that support will be provided from other areas of the hospital, if required.

The Adult Support and Protection (Scotland) Act 2007 was introduced to give greater protection to adults at risk of harm or neglect. All Scottish NHS boards have a duty to refer where they know or believe an adult to be at risk. More information can be found here.

Adult support and protection training is provided to NHS Scotland staff to enable staff to ensure the protection and wellbeing of adults at risk of harm, including how to report concerns relating to an adult who is being harmed, or at risk of harm. NHS Highland website advises that all staff should complete the online training module for

adult support and protection. NHS Highland training compliance varies across the hospital from 64.7% to 10.35%. We can also see that a number of staff have completed Adults with Incapacity training. Compliance figures again vary from 22.52% to 61.5%.

Whilst there are no inpatient paediatric services in Lorn and Island Hospital, paediatric patients are treated in the emergency department. A total of 37.5% of the emergency department staff have completed child protection training. During our corresponding inspection at Raigmore Hospital on Monday 28 until Wednesday 30 October, we also observed low compliance in some areas of mandatory training. A requirement has been given in both inspection reports to support improvement in this area.

NHS Highland use a board wide nursing assessment and care plan booklet. This is a 16 page booklet, and includes but is not exhaustive of, an initial nursing assessment, patient plan of care, including short term and daily care plan. Hospital mandatory assessments are also included. For example, falls and bed rails risk assessments and, a malnutrition screening tool. Patient care booklets that we were able to observe were not always completed fully or updated regularly. Inspectors observed that whilst care plan templates were generally completed, there was limited information or evidence of ongoing review. We also observed variation in the completion of risk assessments. We raised this with staff who told inspectors that the admission booklet was time consuming and cumbersome to use. Inspectors also observed that do not attempt cardiopulmonary assessment documentation were not always completed fully. We raised incomplete care documentation with hospital managers at the time of inspection. A requirement has been given to support improvement in this area.

Standard infection control precautions should be used by all staff at all times to minimise the risk of cross infection. Standard infection control precautions 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 fluid spillages, linen and waste management and prevention and exposure management (such as sharps injuries).

One of the key precautions in infection prevention and control is the practice of good hand hygiene. We observed that the majority of staff were compliant with hand hygiene and there was a good provision of alcohol-based hand rub. However, we also observed several staff wearing rings with stones in them. These could damage a patient's skin and is not in compliance with NHS Scotland national uniform policy, dress code and laundering policy. A requirement has been given to support improvement in this area. We observed patients were not assisted or prompted with hand hygiene prior to meals being distributed. A recommendation has been given to support improvement in this area.

Transmission-based precautions are additional infection control precautions that should be used by staff when caring for a patient with a known or suspected infection.

We observed good signage in place to identify which areas required transmission-based precautions. However, we observed on two occasions that despite signage being in place that patient side room doors should be closed, that they were left open. We raised this with hospital managers at the time of our inspection. A requirement has been given to support improvement in this area.

Other standard infection control precautions include the safe management of waste including linen and sharps. We observed good compliance with sharps and used linen management, with sharps boxes labelled and managed as per guidelines.

We observed that patient equipment was clean, ready to use and storage cupboards, whilst full, were clean and tidy.

All areas of the hospital we visited including general corridors and reception were clean, tidy and uncluttered including patient bed areas. Domestic staff were visible throughout the hospital and described good support from line managers, ward staff and the infection prevention and control team. The environment appeared to be in a good state of repair. Staff we spoke with described good teamwork with the hospital estates team including being responsive to high priority repairs and prioritising high priority requests.

We observed that cleaning products were not always stored securely and could be accessed by patients or members of the public. This is not in line with the Control of Substances Hazardous to Health (COSHH) Regulations 2002. We raised this with staff at the time of inspection. We also observed poor compliance with the safe storage of cleaning products in our corresponding inspection at Raigmore Hospital. A requirement has been given in both inspection reports to support improvement in this area.

Areas of good practice

Domain 4.1	
3	Patients were complimentary about their care and the staff providing it.
4	Domestic staff were visible throughout the hospital with all areas visited tidy and cleaned to a high standard.
5	Medications were stored securely in all areas inspected.

Recommendation

Domain 4.1	
1	NHS Highland should ensure that patients are assisted with hand hygiene prior to mealtimes where required.

Requirements

Domain 4.1	
9	NHS Highland must ensure that all patient documentation is accurately and consistently completed. This includes Adults with Incapacity section 47 documents and do not attempt cardiopulmonary resuscitation documentation.
10	NHS Highland must ensure all staff comply with the appropriate wearing of jewellery.
11	NHS Highland must ensure that all staff comply with required transmission-based precautions.
12	NHS Highland must ensure all hazardous cleaning products are securely stored.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

Workforce pressures and recruitment challenges continue to be experienced throughout NHS Scotland. Hospital managers advised that the remote and rural location of Lorn and Islands Hospital has added challenges to recruitment into vacancies as well as reduced availability of supplementary staff.

NHS Highlands workforce plan for 2022–2025 highlights the remote and rural location and lack of availability and affordability of accommodation as a challenge in recruiting staff. Hospital managers advised that this is a particular challenge for staff relocating to the Oban area. In an attempt to mitigate this, Lorn and Islands Hospital has two rental properties available which new staff can use until they are able to find alternative accommodation. We were also advised that Lorn and Islands Hospital has links with a local hotel to assist with accommodation for supplementary staff.

We can see that the challenges in recruiting nurses, allied health professionals and medical staff at Lorn and Islands Hospital is entered on NHS Highlands risk register. Local initiatives to improve recruitment include Open University training for registered nurses to enable advancement of staff with two to four health care support workers from the hospital supported through the training to become registered nurses yearly. Lorn and Islands Hospital has also successfully recruited a number of international nurses.

Documented control measures for medical vacancies include long term and regular locum medical staff and recruitment to rural emergency practitioner posts to support the emergency department. Rural emergency practitioners are senior medical staff whose role includes working within the multi-disciplinary team to provide senior decision making and clinical skills that are required within the emergency department and hospital.

Workforce data provided by hospital managers include vacancy and sickness rates for nursing staff. We can see from these that there was a high level of band 5 registered

nursing vacancies, with one area at 41.8%. This ward also has the highest sickness rate at 16.4%. Hospital managers advised that NHS Highland has a recruitment team who support and work with team leads and managers throughout the recruitment process and, that since our on-site inspection, successful recruitment has dropped the vacancy rate to 26.15%. We can also see that recruitment has been successful for the emergency department which previously had a vacancy rate of 23%. Hospital managers advised that sickness absence is managed through the NHS Scotland attendance policy. This is a national policy that provides guidance to managers in supporting staff during absence.

We asked hospital managers how risk was mitigated in the ward area that had high sickness and vacancy rates and therefore, potential high use of supplementary staff. We were advised that shifts were covered by supplementary staff who are familiar with the ward, including some who were previously substantive members of the ward team, who now work on the hospital nurse bank. Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's staff bank or staff from an external agency. During our onsite inspection we observed that the majority of ward nursing staff were substantive staff with the exception of one agency nurse who was familiar with the ward. Staff told inspectors that the majority of supplementary staff are familiar with the hospital.

All areas we visited during our onsite inspection were calm and well organised and staff did not raise any concerns relating to staffing with all areas having the agreed staffing numbers in place. However, staff told inspectors that it was sometimes difficult to fill staff shortages with supplementary staff especially registered nurses and described the process of requesting staff as time consuming. Evidence returned includes a submitted incident report relating to staff shortages which was escalated to hospital managers and an urgent request for supplementary staff approved. However, the incident report documents that the request had not been responded to. We can see that this incident has been reviewed and mitigating actions put in place including re-confirmation of the booking process for supplementary staff. Of the other incident reports submitted relating to staffing, only one other relates to staff shortages on the wards. There were no reports relating to patient harm as a result of these staff shortages. However, it is documented in one that patient care was compromised and a member of nursing staff worked additional hours on the night shift to provide support despite working hours during the day shift.

We were able to observe the Lorn and Islands Hospital wide safety huddles. These are held in the morning and are face to face meetings held on one of the wards. Members of the multidisciplinary team were represented at the huddle including social work, support services, infection control and the hospital at home team. Staffing was discussed, including the shortage of two healthcare support workers over night which had been escalated for cover. However, it was not discussed how risk would be mitigated if the shifts were unable to be covered with supplementary staff and,

patient acuity and dependency was not discussed other than in one ward area where staff highlighted that they had one patient who required 1:1 observation.

We were provided with the Lorn and Islands Hospital safety huddle template for the safety huddle we attended. We can see from this that it documents no urgent issues were raised, which reflects our observations at the huddle. The number of patients in the emergency department and ward capacity is documented, as is number of surgical cases planned for the day, including the number requiring general anaesthetic. However, the template does not capture staffing numbers or patient acuity and dependency or mitigation.

NHS Highland has a twice daily board-wide safety huddle. However, we did not have the opportunity to attend this whilst on site at Lorn and Islands Hospital. During the concurrent inspection, Raigmore hospital inspectors were able to attend the NHS Highland board-wide safety huddle. Inspectors advised that whilst staffing at Lorn and Islands Hospital was discussed, the safety huddles had little focus on patient acuity and mitigation of risk in relation to real time staffing requirements. A requirement has been given to support improvement in this area.

Hospital managers advised that ward staff at Lorn and Islands Hospital complete a ward-based electronic real time staffing template to record patient acuity and dependency. We were provided with a completed template from January 2025 and can see from this that patient acuity and dependency was recorded, as was escalation to senior staff. However, hospital managers have been open and transparent in highlighting that ongoing improvement is required in relation to compliance and completion of the template.

Time to lead is a legislative requirement under the Health and Care (Staffing) (Scotland) Act (2019). This is to enable clinical leaders to ensure they have protected time and resource to ensure appropriate staffing alongside other professional duties to provide the delivery of safe, high quality and person-centred healthcare. Whilst we were only able to talk with one senior charge nurse during our onsite inspection, they advised that they had sufficient time to lead.

Evidence provided by NHS Highland includes the draft for consultation, adequate time given to clinical leaders (time to lead) standard operating procedure. The purpose of the standard operating procedure is highlighted as supporting health care teams within NHS Highland to fulfil the requirements of the Health and Care Staffing (Scotland) Act. It is documented that NHS Highland has a roll-out plan underway to implement a new electronic system to capture real time staffing, including time to lead. However, it is anticipated that this will take some time to complete and, until then, time to lead should be recorded on the current electronic staffing template.

The time to lead standard operating procedure includes the process to identify severe and recurrent staffing risk. This includes monthly review of staffing related incident reports by senior managers to identify risks and trends with monthly discussion at the

senior leadership team meetings. This operating procedure is in draft form and dated November 2024 and was therefore, not in place during our onsite inspection.

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), which encompassed the requirement to use the mandated staffing level tools. The application of the common staffing method and staffing level tools supports NHS boards to ensure appropriate staffing, health, wellbeing and safety of patients and the provision of safe and high quality care.

We can see in evidence provided that whilst a staffing level tool was completed in September 2024 for one of the areas inspected, that this had a data input error. Therefore, could not inform appropriate staffing levels. A requirement has been given to support improvement in this area.

Hospital managers advised that a workforce tool/establishment setting is currently being undertaken with the aim of completion by the end of March 2025.

Area of good practice

Domain 4.3	
6	There are a number of initiatives in place to improve the challenges of recruiting to a remote and rural area.

Requirements

Domain 4.3	
13	NHS Highland must ensure that hospital safety huddles consider decision making regarding real time staffing risks and mitigations and that these are documented and aligned with patient acuity and dependency to support skill mix and staffing.
14	NHS Highland must ensure that there are processes in place to support the consistent application of the common staffing method. This includes 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

We observed staff working hard to provide compassionate and responsive care and patients were complimentary about their care and the staff providing it.

We observed that patients were treated with dignity, respect, kindness and compassion and all interactions between staff and patients were positive and, patients described staff as responsive when they required assistance. Patient privacy screens were used appropriately to maintain patient privacy and dignity.

An Adults with Incapacity (Scotland) Section 47 Certificate is a legal document which assists the patient, their family and staff to make decisions about the patient's care when the patient is unable to do so independently. Inspectors observed that not all Adults with Incapacity Certificates were completed fully and, in one instance, was two weeks out of date. We raised this with staff at the time of the inspection who updated the certificates appropriately.

In one ward area, we observed that an Adults with Incapacity (Scotland) Section 47 Certificate was in place for a patient to receive medical treatment. However, staff advised that the patient was no longer receiving treatment as was clinically fit for discharge but awaiting housing allocation. Ward staff told us that there had been a multidisciplinary team meeting in regard to the patients care. However, this did not appear to be documented. We raised this with staff and hospital managers at the time of the inspection who were responsive in ensuring a timely review of the patients care needs and Adults with Incapacity (Scotland) Section 47 Certificate. We were assured this was addressed during the inspection.

During our onsite inspection, staff told us of the involvement and assistance of the dementia team, who they felt, had been of great support in providing advice and assistance to staff to support a patient who had been experiencing stress and distress.

Area of good practice

Domain 6	
7	Staff were working hard to provide compassionate and responsive care. Staff told us of the support of the dementia team to support individual patient centred care.

Appendix 1 - List of national guidance

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

- Allied Health Professions (AHP) Standards (Health and Care Professionals Council Standards of Conduct, Performance and Ethics, September 2024)
- Ageing and frailty standards – Healthcare Improvement Scotland (Healthcare Improvement Scotland- Draft standards out for comment)
- 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, 2022)
- National Infection Prevention and Control Manual (NHS National Services Scotland, October 2024)
- Healthcare Improvement Scotland and Scottish Government: operating framework (Scottish Government & 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, June 2024)
- The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (Nursing & Midwifery Council, October 2018)

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