Unannounced Inspection Report

Acute Hospital Safe Delivery of Care Inspection

Raigmore Hospital

NHS Highland

28-30 October 2024

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

Raigmore Hospital is the District General Hospital serving the population of the Highlands. It provides a range of specialities such as orthopaedics, general surgery, acute medicine, oncology and paediatrics.

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.

We carried out an unannounced inspection to Raigmore Hospital, NHS Highland on Monday 28 to Wednesday 30 October 2024 using our safe delivery of care inspection methodology. We inspected the following areas:

- ambulatory emergency care
- critical care unit
- emergency department
- flow centre
- ward 2a
- ward 3b
- ward 3c
- ward 4a
- ward 4b
- ward 4c
- ward 5a
- ward 5c
- ward 6a
- ward GA

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.

On 27 November and 2 December 2024, we held a virtual discussion session with key members of NHS Highland staff to discuss the evidence provided and the findings of the inspection.

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

We would like to thank NHS Highland and in particular all staff at Raigmore 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'.

Despite significant pressures on hospital capacity, we observed teams working closely to provide safe and effective care. Patients and families inspectors spoke to were complimentary about the staff and care provided. Staff described supportive management and access to a variety of initiatives to support wellbeing. The majority of wards were calm and well organised with good leadership. Senior charge nurses or the nurse in charge could be easily identified and were approachable.

NHS Highland demonstrated strong support for newly qualified nurses and assistant practitioners. Some staff explained to inspectors that whilst they would report an incident involving a patient on the electronic incident reporting system, they were unlikely to report staffing incidents such as poor skill mix or lack of available staff.

We raised concerns to senior managers regarding the use of additional beds and oversight of infection control risks. Whilst the additional beds were in standard bed spaces, there was a lack of substantive staff available in these areas and as a result we observed a high use of supplementary staff in the areas using additional beds. We also identified that there had been instances where infection outbreaks had not been reported in accordance with current guidelines.

Further areas for improvement that have been identified include ensuring staff are trained in fire evacuation, staff compliance with standard infection control precautions such as hand hygiene, correct use of personal protective equipment and ensuring all patients have access to call bells and suitable toilet and showering facilities.

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

This inspection resulted in 12 areas of good practice and 13 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 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 Raigmore Hospital resulted in 12 areas of good practice.

Domain 1	
1	The emergency department have developed processes to ensure patients receive the right care in the right place using signposting and redirection guidance (see page 15).
2	NHS Highland have developed innovative ways to share education regarding falls with patients (see page 15).
3	The senior leadership team in the emergency department have good oversight of risks and challenges arising from patients being delayed in the department (see page 15).
4	Staff training compliance in both immediate and paediatric immediate life support was high (see page 15).

Domain 2	
5	Staff described supportive leadership from senior charge nurses and clinical nurse managers (see page 18).
6	Staff in the emergency department and intensive care unit have developed peer support networks (see page 18).
7	The spiritual care team provides additional support to staff awaiting input from counselling services (see page 18).

Domain 4.1	
8	Mealtimes were well organised and patients were supported with hand hygiene prior to meals (see page 25).

Domain 4.3	
9	NHS Highland offer good support to newly qualified nurses and band 4 assistant practitioners (see page 29).
10	Staff are supported to develop quality improvement projects (see page 29).

Domain 6	
11	We observed staff to be kind and caring (see page 31).
12	Staff in Raigmore Hospital have developed a range of activities for patients to participate in whose discharge is delayed (see page 31).

Requirements

The unannounced inspection to Raigmore Hospital resulted in 13 requirements.

Domain 1
1   NHS Highland must ensure all staff are trained to ensure safe fire evacuation (see page 15). This will support compliance with: NHS Scotland 'Firecode' Scottish Health Technical Memorandum SHTM 83 (2017) Part 2; The Fire (Scotland) Act (2005) Part 3, and Fire Safety (Scotland) Regulations (2006).

Domain 4.1
2   NHS Highland must ensure all patients have access to a call bell (see page 25). 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.
3   NHS Highland must ensure all staff comply with hand hygiene and the correct use of Personal Protective Equipment (see page 25). This will support compliance with: National Infection Prevention and Control Manual (2023)
4   NHS Highland must ensure that all staff comply with the safe storage of linen (see page 25). This will support compliance with: National Infection Prevention and Control Manual (2023)
5   NHS Highland must ensure that all staff comply with safe sharps management (see page 25). This will support compliance with: National Infection Prevention and Control Manual (2023).
6   NHS Highland must ensure that the hospital environment is maintained to facilitate effective cleaning (see page 25). This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022), Healthcare Associated Infection (HAI) standards (2015) Criterion 8.1 and Health and Social Care Standards (2017) Criteria 5.24.
7   NHS Highland must ensure cleaning products are stored safely and securely (see page 25).

	This will support compliance with: Control of Substances Hazardous to Health (COSHH) Regulations (2002)
8	NHS Highland must ensure that a risk assessment is completed when prioritising patients for single room accommodation and that there are systems and processes for staff to monitor and escalate concerns regarding lack of available single room accommodation (see page 25). This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022).
9	NHS Highland must ensure all healthcare infection incidents, including previously unreported incidents, are reported in line with guidance within the national infection prevention and control manual. (see page 25). This will support compliance with: National Infection Prevention and Control Manual (2023), Infection Prevention and Control Standards (2022) and Protocol for the Reporting of Healthcare Infection Incidents, Outbreaks and Data Exceedance in NHS Scotland through the Outbreak Reporting Tool (ORT).

Domain 4.3

10	NHS Highland must ensure appropriate staffing is in place that is reflective of the number and care needs of patients. This should include recording of clinical professional judgement of real-time staffing requirements, including evidence of how decisions are reached and communicated (see page 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
11	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 29). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.
12	NHS Highland must ensure all staff are able to access training required for their role (see page 30). This will support compliance with: Health and Care (Staffing) (Scotland) Act 2019.

Domain 6	
13	NHS Highland must ensure patient dignity is maintained at all times. This includes, but is not limited to, access to suitable toilet and shower facilities for patients requiring mobility aids (see page 31). 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.

What we found during this inspection

Domain 1 – Clear vision and purpose

Quality indicator 1.5 – Key performance indicators

Despite significant pressures on hospital capacity, we observed teams working closely to provide safe and effective care.

At the time of this inspection NHS Highland, like much of NHS Scotland, was experiencing significant pressures including increased hospital capacity, delayed discharges and increased waiting times in the emergency department. During our inspection the hospital was operating at 103% bed occupancy. The British Medical Association and the Royal College of Emergency Medicine describe a safe bed occupancy level of less than 85%.

Senior managers explained to us that hospital capacity presents a significant challenge with approximately 80 to 85 patients daily experiencing a delay to being discharged from hospital. A delayed discharge occurs when a patient who is medically fit to be discharged from hospital cannot leave the hospital due to a lack of care, support or suitable accommodation such as a nursing home placement. In response to the increased demand, NHS Highland explained that additional beds have been opened.

We asked NHS Highland to provide us with risk assessments relating to the use of additional beds. We were provided with a risk assessment that guides staff on the most suitable patient to be placed in an additional bed in a non-standard bed space such as a treatment room. This highlighted that patients being moved to a non-standard bed space must not have a cognitive impairment, be able to mobilise with minimal assistance and not require care such as intravenous medication, complex wound care or oxygen therapy. Inspectors did not observe patients being cared for in non-standard care areas such as treatment rooms or corridors during our onsite inspection. All additional beds inspectors observed had been created by re-opening previously closed ward areas meaning that all patients had access to call bells, oxygen,

suction and electrical sockets. The impact on the use of these additional beds for both patients and staffing will be discussed later in the report.

Senior managers explained that an urgent review was underway to assess how to increase capacity within NHS Highland care homes, Care at Home and the community hospitals to reduce the number of delayed discharges. In evidence submitted we also observed that significant work had been undertaken to review the current bed capacity for Raigmore Hospital. In this evidence we could see that the additional beds that are in use are currently staffed using supplementary staff. Supplementary staff are staff from either the NHS boards' own staff bank or from an external agency. We observed that the senior management team have recommended that forty two of the additional beds that have been opened should have funding approved to enable a substantive nursing workforce. Staffing will be discussed in more detail in Domain 4.3 of this report.

Inspectors observed that in two wards the fire evacuation plans did not appear to have been updated since 2019. One of these wards had been identified as a ward that may use the treatment room as a non-standard care area as an additional bed during times of extreme capacity pressures. During our virtual discussion session senior managers explained that this had been rectified immediately following inspectors raising this at the time of inspection and provided evidence of updated fire risk assessments for both wards.

We were provided with fire safety training compliance by NHS Highland. In this we can see that 60% of all staff in Raigmore Hospital are trained in fire safety. Further evidence returned to us by NHS Highland included the action plan submitted to the Scottish Fire and Rescue Service following an audit in November 2024. This highlighted that NHS Highland would review fire training plans at the Fire Safety Committee in February 2025. A requirement has been given to support improvement in this area.

The national target for accident and emergency waiting times means that 95% of patients should wait no longer than four hours from arrival at the emergency department before admission, discharge or transfer for other treatment. During the week of our onsite inspection, 63.9% of patients were seen within the four hour target across NHS Scotland with 69.7% of patients seen within four hours at Raigmore Hospital. During this week, 4.2% of patients waited over 12 hours in Raigmore Hospital's emergency department before being admitted, discharged or transferred to another area. Further information on emergency department attendances can be found here.

Inspectors observed that the emergency department was calm with all patients being cared for in a designated cubicle and had access to call bells. Nursing staff explained to inspectors that patients who were in the department for over twelve hours would be transferred onto a hospital bed for comfort. During our onsite inspection we did not observe this as no patients had been in the department for this length of time.

Scottish Government emergency signposting guidance seeks to ensure patients receive care in the most appropriate setting whilst helping to improve waiting times and delays in emergency departments and acute admission units. Further information can be found at emergency department signposting/redirection guidance. We were provided with NHS Highland's signposting and redirection policy which aims to support patients to receive the right care, at the right time and the right place whilst also ensuring that the emergency department has the capacity to deliver emergency care. This described how senior nursing or medical staff in the emergency department may redirect patients attending the department to more suitable services such as pharmacy or dental services. Patients that are redirected to another service will be given an information leaflet explaining the redirection process, links to NHS Inform and a reminder that patients can call NHS24 for advice prior to attending an emergency department.

Inspectors were told that there may be delays transferring patients from ambulances into the emergency department when it is full. The patients that are waiting to be transferred remain under the care of colleagues from the Scottish Ambulance Service until a space becomes available in the department. We did not observe any delays to patients being transferred into the emergency department during our onsite inspection. Nursing staff explained to inspectors that these delays did happen on a regular basis and that any delay of over three hours was reported on the electronic incident reporting system. We were told that when long ambulance waits occur nursing staff and senior medical staff will liaise with Scottish Ambulance Service crews who wait with patients. As there were no ambulances waiting during our onsite inspection, inspectors did not have the opportunity to talk with ambulance staff.

As part of the inspection, we asked NHS Highland to provide evidence of any incidents or adverse events reported by staff through the incident reporting system for the three months prior to our inspection. 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.

Within these reports we did not see any incident reports raised where patients waited over three hours in ambulances to be transferred into the emergency department. However, we did observe one incident where a patient had become critically unwell whilst waiting less than an hour to transfer from an ambulance into the emergency department. We discussed this with senior managers who explained that this incident had been reviewed and discussed at the Quality and Patient Safety weekly incident meeting.

In evidence submitted by NHS Highland we can see that feedback from this incident has been shared with colleagues in the Scottish Ambulance Service and the emergency

department team following the review. A significant adverse event review should be carried out to support learning from adverse events and has an important contribution to make to improve the quality and safety of care. To support this process there is a National Framework for Scotland - Learning from adverse events through reporting and review. Senior managers explained that it had been identified that recording and escalating of a patient's National Early Warning System2 (NEWS2) has been fed back to the Scottish Ambulance Service. NEWS2 is a tool that measures a patient's physiological measurements such as blood pressure and pulse. It identifies patients who are at risk of or have become unwell in order for medical and nursing staff to respond.

NHS Highland also provided us with evidence of the Joint North Highland Rural Transfer Governance committee. This has been developed to provide joint governance between NHS Highland and the Scottish Ambulance Service and will review incidents that have been identified through either the NHS Highland Acute Services validation meeting or the Scottish Ambulance Service patient safety and quality meeting.

We observed that the most commonly reported patient safety incidents included slips, trips and falls. Further evidence provided by NHS Highland highlighted improvement work that has been undertaken in relation to falls. This included a draft version of the 'NHS Highland Prevention & Management of Falls Policy – Inpatient/All Hospital Guidance'. This policy aims to reduce the incidence of falls by using evidenced based guidance. This includes ensuring all patients are screened for their risk of falls by use of assessments such as moving and handling assessments and bedrail risk assessments as well as the falls risk assessment. During our inspection, inspectors were able to review some patient care documentation and observed that these risk assessments were well completed. Senior managers also explained that further improvement work includes a monthly NHS Highland Falls Steering group which shares learning to staff via the NHS Highland Falls Awareness newsletter. We were provided with the most recent version of this newsletter which provided education to staff on orthostatic hypotension, which is a sudden drop in blood pressure that occurs after standing from a seated or lying down position and is a potential cause for falls.

NHS Highland also shared other initiatives that have been developed to help reduce falls including a collaboration with NHS Highland, the 'End PJ Paralysis' campaign where a cartoon strip provides education around encouraging patients to keep active and to reduce their risk of falls. The resource highlights the risks of deconditioning and uses familiar Scottish cartoon characters to stress the importance of staying active, even in the hospital. We were also provided with the NHS Highland falls audit that wards with higher incidences of falls will use. This tool will identify any themes surrounding falls and records any potential changes to practice that may lead to improvements.

Raigmore Hospital provides inpatient paediatric services and paediatric patients may also be assessed and treated within the emergency department. Most nursing staff

within the emergency department are trained to provide adult care. As part of the inspection, we requested the current paediatric immediate life support training provision at Raigmore Hospital for staff working in the emergency department and the paediatric inpatient ward. This course is developed by the Resuscitation Council UK for health professionals who may have to manage and treat paediatric patients in an emergency. 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. In evidence returned to us, we observed that 90% of both emergency department nursing and paediatric ward nursing staff have completed paediatric immediate life support training.

NHS Highland also provided evidence of immediate life support and advanced life support training compliance for the emergency department and the acute medical admission's ward. Immediate life support was developed by Resuscitation Council UK for healthcare professionals who may have to act as the first responder in an emergency, giving them the skills to manage adult patients in cardiac arrest before a cardiac arrest team arrives. Advanced Life Support provides skills in adult cardiopulmonary resuscitation (CPR) as well as the recognition and management of a deteriorating patient and skills in leading a team. From the evidence provided we can see that 90% of nursing staff in the emergency department and 85% of nursing staff in ward GA are trained in immediate life support. In addition, 25% of emergency department and 58% of nursing staff in ward GA are trained in advanced life support.

Areas of good practice

Domain 1	
1	The emergency department have developed processes to ensure patients receive the right care in the right place using signposting and redirection guidance.
2	NHS Highland have developed innovative ways to share education regarding falls with patients.
3	The senior leadership team in the emergency department have good oversight of risks and challenges arising from patients being delayed in the department.
4	Staff training compliance in both immediate and paediatric immediate life support was high.

Requirement

Domain 1	
1	NHS Highland must ensure all staff are trained to ensure safe fire evacuation.

Domain 2 – Leadership and culture

Quality indicator 2.1 – Shared values

Staff described supportive management and the majority of staff felt safe to raise patient care concerns via the electronic incident reporting system. However, some staff described not completing electronic incident reports in regard to staffing concerns. Staff described access to a variety of initiatives to support wellbeing.

We attended the hospital safety huddles as part of the inspection. The purpose of a safety huddle is to provide site situational awareness, understand patient flow and raise issues such as patient safety concerns, review staffing and identify wards or areas at risk due to reduced staffing levels. The huddles included a wide representation from the multidisciplinary team including staff from nursing, allied health professionals, estates and facilities. During these we observed that senior managers had good oversight of any flow and capacity issues throughout the hospital and that there was an opportunity for teams to raise any safety concerns.

In evidence provided, we observed that NHS Highland utilise the Operational Pressures Escalation Levels (OPEL) Framework, the aim of which is to ensure patient and staff safety and outlines the leadership and actions required during times of extremis in the hospital system. The OPEL Framework has a five level stepped response ranging from level one as the lowest response to level five as the highest level.

Throughout our onsite inspection the hospital was operating under level four of the OPEL Framework. In response to this level, two additional tactical escalation meetings were held at 10am and 1.30pm. We were able to attend one of these meetings and observed that these were attended by senior managers from both NHS Highland and the Scottish Ambulance Service. We observed discussions in these meetings were open, supportive and provided the senior management team with good oversight of the continued pressures that were being faced.

All areas inspected were busy, however, the majority of wards were calm and well organised. Inspectors observed good teamwork with staff providing safe and effective care. The majority of nursing staff that inspectors spoke to reported very good senior leadership and felt supported to do their job well. Senior nurses were visible throughout the hospital during our onsite inspection.

We did not have the opportunity to talk with student nurses during the inspection however, inspectors observed that one ward had recently received an award from the University of the Highlands and Islands due to exceptional support in clinical practice for students.

Inspectors did not observe any departmental or ward huddles during our inspection as they occurred out with the times of inspectors being in clinical areas. We were told that the emergency department hold a number of safety huddles. These included

nursing huddles held at the start of a shift as well as medical huddles held in the early afternoon and at shift changes later in the day. We were told that there was an informal process for holding more regular huddles when the department was over capacity.

Whilst inspectors did not observe ward safety huddles, they were told that regular ward safety briefs took place which detailed patient safety concerns such as falls risks as well as staffing concerns and shared learning from any recent electronic safety incident reports. In one ward area inspectors were told that a multi-disciplinary meeting was held in the morning, attended by nursing, medical and allied health professionals. This meeting enabled staff to discuss changes in patient's care as well as highlighting any information from the earlier hospital huddle or ward safety brief.

Nursing staff that inspectors spoke with felt safe to report safety incidents involving patients via the electronic incident reporting system and that they will receive feedback following the incident being reviewed. However, a number of nursing staff reported that whilst they would report patient care incidents, they did not consistently record staffing concerns such as poor skill mix or staffing shortages on this system. Inspectors were told that staffing concerns were not always recorded due to staff fatigue following a busy shift and staff did not perceive the value of reporting these concerns. In evidence submitted by NHS Highland we can see that senior managers had identified potential under-reporting of staffing incidents on the electronic incident reporting system.

We raised this with senior managers during our virtual discussion session who acknowledged that there was probable under-reporting of staffing concerns via the incident reporting system. It was explained that OPEL staffing levels are recorded at each huddle which capture nurse: patient ratios. Senior managers explained that they are assured that staffing concerns are captured effectively with regular check ins between senior managers and ward teams as well as the use of a staffing sheet that records staffing requirements throughout the site. The staffing sheet is updated via an online system enabling senior managers to have real time updates throughout the day. This will be discussed in more detail in domain 4.3 of the report.

NHS Highland have several initiatives to support staff's emotional wellbeing following a distressing incident such as violence and aggression. During our discussion session senior managers explained that a debrief will be completed and we were provided with a copy of the debrief tool in evidence returned to us. This document highlights to staff undertaking the debrief that the session is not to determine blame but should be used as an opportunity to improve care. We were also told of additional support mechanisms offered to staff such as the spiritual care team, peer support, management support and access to the Occupational Health service.

Inspectors were also told by staff of support networks available to them including a wellbeing room for staff based in the intensive care unit. Staff in this area were keen

to praise the spiritual care team who were described as extremely helpful and supportive, especially when staff are awaiting talking therapies such as counselling services.

Staff in the emergency department also described excellent peer and management support offered following any potentially emotionally distressing events. We were also told of a weekly newsletter circulated to the emergency department team with details of upcoming training, changes in processes, achievements and details of thanks received from patients and their families.

Areas of good practice

Domain 2	
5	Staff described supportive leadership from senior charge nurses and clinical nurse managers.
6	Staff in the emergency department and intensive care unit have developed peer support networks.
7	The spiritual care team provides additional support to staff awaiting input from counselling services.

Domain 4.1 – Pathways, procedures and policies

Quality 4.1 – Pathways, procedures and policies

The majority of wards were calm and well organised with good leadership. We observed that patients in all areas inspected appeared comfortable, well cared for and staff were responsive to patients' needs. However, we identified instances where reporting of infection outbreaks had not been followed in line with current national guidance.

We observed that patients in all areas inspected appeared comfortable, well cared for and staff were responsive to patients' needs. Patients and visitors were complimentary about staff and the care they provided. Whilst we did not observe delays to care during our inspection, some patients did mention that there had been incidents where they had experienced delays in receiving care such as timely access to pain relief. We did not observe patients being cared for in non-standard care areas.

Patients had access to call bells although in one ward these were out of reach for the majority of patients. Inspectors observed that there was a high level of patient dependency in this ward with several patients requiring assistance from more than one member of staff at a time. Inspectors also observed that call bells that patients did have access to, and were using, were not answered promptly in this clinical area. Inspectors raised this with the nursing staff at the time of inspection. During our corresponding inspection with Lorn and Islands Hospital we also observed that call

bells were not always within easy reach for patients. A requirement has been given in both inspection reports to support improvement in this area.

Inspectors found that the majority of patient care documentation was well completed. Nursing staff in Raigmore Hospital utilise a booklet called the 'Hospital Mandatory Nursing Assessments' which records a number of assessments including falls risk assessment, bed rails assessment, and malnutrition screening tool. In ward areas inspectors observed the use of the 'Daily Care Plan'. The 'Daily Care Plan' is a single page document that records continence, nutrition, pressure area care, oral hygiene, equipment checks such as pressure relieving mattresses and whether a patient requires support with meaningful activities. It also records a 'Safe Care Pause' which is used to prompt staff to routinely review a patient at specific times if they are unable to use a call bell reliably to request assistance. Inspectors found that the majority of patient documentation was completed to a high standard. Inspectors observed good completion of National Early Warning Score2 (NEWS2) charts. NEWS2 charts are used to record a patient's physiological parameters such as pulse and blood pressure and will alert staff if a patient is at risk of deterioration.

Nursing staff in the emergency department explained to inspectors that they do not use the 'Daily Care Plan' documentation and instead will record all care into the patient notes. Inspectors observed that some risk assessments such as frailty and Waterlow scores were not completed for patients in the emergency department. A Waterlow score identifies patients at risk of developing pressure damage. This was raised with the senior charge nurse at the time of inspection who advised that this would be rectified and shared with the emergency department team for further learning.

Inspectors observed Adults with Incapacity Section 47 Certificates completed for a number of patients throughout the hospital. These are legal documents which assist patients, their families and staff to make decisions regarding a patient's care and treatment when the patient is unable to make the decision independently. We observed that the majority of these were well completed however, one certificate had expired a month earlier. Inspectors raised this with the nurse in charge who ensured this was rectified immediately.

NHS Highland has developed a standardised document for adults containing Adults with Incapacity section 47 certificates and associated care plans as well as enhanced observation care plans. As described earlier in the report, patients may require an enhanced level of observation to reduce the risk of harm for reasons such as an increased risk of falls, risk of self-harm or a risk of absconding. The document can also be used to record discussions with relatives and carers and is kept within the main patient care record. These documents were clear, detailed and completed appropriately.

We observed patient mealtimes were well organised with mealtime coordinators taking a lead in most areas. Inspectors observed patients being encouraged to perform hand hygiene prior to meals by use of hand wipes. We observed that the meals were distributed in a timely manner with patients receiving assistance when required. Inspectors observed that staff who were assisting patients with meals did not rush patients and spent time talking to them during the meal. Patients inspectors spoke with in the emergency department confirmed that they had been offered breakfast, sandwiches and had access to drinks.

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

Hand hygiene involves '5 moments' when hand hygiene should be performed. These are prior to touching a patient, prior to performing a procedure, after procedure or body fluid exposure risk, after touching a patient or after touching a patient's surroundings. In the majority of areas of the hospital we observed good compliance with hand hygiene. However, inspectors observed that in one ward staff missed hand hygiene opportunities in all five of these occasions. This was fed back to the nurse in charge of the area at the time of inspection. NHS Highland shared with us the minutes of the Acute Services Division Clinical Governance Committee meeting held in September 2024. In this we observed that hand hygiene was highlighted as an area for improvement within Raigmore Hospital with poor compliance noted from all staff groups.

Alcohol based hand rub was available throughout the majority of the hospital as well as good availability of personal protective equipment. In most areas, we observed staff using the personal protective equipment appropriately. However, in the ward in which inspectors observed poor compliance with hand hygiene, we also observed that staff did not consistently change aprons and gloves in between providing care to patients. This was fed back to the nurse in charge at the time of inspection. A requirement has been given to support improvement in both hand hygiene compliance and the appropriate use of personal protective equipment.

Clean linen should be stored in a linen cupboard with the door closed or an appropriate identified covered trolley to minimise the risk of contamination. Inspectors observed that in some areas the covers on clean linen storage trollies were not always in place. Inspectors observed that in several ward areas staff were not placing the alginate bags containing soiled linen into a clear outer bag. This is not in line with national guidance. Used linen that has been used by a patient who is known or suspected to be infectious or linen that is contaminated with blood and/or other bodily fluids should be placed into a water soluble alginate bag then placed into a clear

bag to prevent the risk of contamination. A requirement has been made to support improvement in this area.

In some areas, inspectors observed poor sharps management compliance with several sharps boxes not being labelled as per guidelines or having temporary closures in use. The use of the temporary closure prevents needles or other sharp objects protruding from the boxes or falling out of the container if it is dropped. Inspectors also observed sharps waste being stored in a medical waste container with no lid. This was raised with the nurse in charge. A requirement has been made to support improvement in this area.

During the inspection the majority of patient care equipment was clean and ready for use. Storerooms were tidy and well organised. The hospital environment appeared clean. However, we observed evidence of wear and tear throughout the hospital. For example, chipped paintwork on doors and door frames and a damaged worksurface within a ward kitchen. Damage to healthcare environments can make it difficult to clean properly. A requirement has been made to support improvement in this area.

Inspectors observed in the majority of areas that chlorine-based cleaning products were not stored securely, resulting in a risk that it may be accessed by patients or members of the public. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 stipulate that these products must be kept in a secure area such as a locked cupboard. We also observed that staff did not label bottles with the date and time of when chlorine-based cleaning products were reconstituted. This would make it difficult for staff to know when the cleaning solution should be discarded. The national infection prevention and control manual recommends cleaning products should be freshly made and discarded after twenty four hours. We also observed poor compliance with the safe storage of cleaning products in our corresponding inspection in Lorn and Islands Hospital. A requirement has been given in both inspection reports to support improvement in this area.

Inspectors were able to talk with members of the domestic team who reported that they felt well supported and were able to complete their duties in the time allocated. They described good working relationships with domestics supervisors and the ward teams.

We observed good compliance with safe medication storage throughout the hospital, with all medication trolleys and storage cupboards locked in the majority of areas. Safe medication storage reduces the risk of medication being taken in error by a patient or a member of the public.

As described earlier in this report, NHS Highland have re-opened previously closed wards or ward areas as a temporary measure to improve capacity within Raigmore Hospital. Inspectors were told by nursing staff in one ward area that this had resulted in the ward capacity increasing from 16 to 30 beds. The original 16 beds in the ward are allocated for patients being treated under a haematology or oncology specialism.

These patients may be more susceptible to infection due to additional risk factors such as being immunocompromised from chemotherapy or steroid use as part of their treatment. The additional 14 beds are allocated to medical patients. The ward operated so that the medical patients were cared for in separate rooms to the haematology/oncology patients.

Staff raised concerns with inspectors that there had been multiple ward closures due to infection outbreaks since the additional beds had been opened and were concerned that this created risks to the haematology and oncology patients. The ward accommodation consisted of a mixture of single and multi-bed rooms, and we observed that bed spacing was compliant with current guidance. Inspectors observed good compliance with the use of personal protective equipment in this ward. We raised the concerns staff had raised with senior managers during our virtual discussion session. We were told that senior staff in this ward work collaboratively with the hospital flow team to ensure the patients being placed in the additional beds meet a selection criteria. These criteria included patients with no known or suspected infections. However, this process did not appear to be embedded as inspectors had observed more than one patient with a known infection being cared for within a multi-bed bay in this ward during our inspection.

We spoke with members of the infection prevention and control team from NHS Highland who advised they were aware of the patients with known infections being cared for in this ward. In guidance provided by National Services Scotland and ARHAI Scotland 'Appendix 11 Best Practice Aide Memoire for Patient Placement considerations and Respiratory Protective Equipment (RPE) of Fluid Resistant Facemasks (FRM) for Infectious Agents', it is recommended that the ideal patient placement for patients with suspected or confirmed infections is single room accommodation however they recognise that the current NHS Scotland estate does not always allow for this. Inspectors observed that a patient being cared for in a six bedded bay in the ward required staff to use transmission based precautions. Transmission based precautions are additional infection, prevention and control measures to prevent cross-transmission of certain infections. We observed good signage in place to identify where transmission based precautions were required.

In evidence provided to us, NHS Highland explained that whilst isolation of patients with an infection was recommended, they were unable to do so consistently due to a lack of single room accommodation. We were told that when demand for single room exceeds capacity then patients requiring isolation are prioritised according to patient symptoms and how safely they can be managed within a multi-bedded bay. This is in line with guidance from National Services Scotland and Antimicrobial Resistance and Healthcare Associated Infection (ARHAI). NHS Highland provided us with a copy of the 'Patient Isolation Decision Tracker' which details the steps staff should follow when a patient develops an infection requiring isolation. In this we can see that if patients requiring isolation cannot be accommodated in a single room, then staff should escalate to the senior nursing team. We were told that this had not been completed

for this incident and that work was ongoing to embed this process with the team. A requirement has been made to support improvement in processes for identifying and prioritising isolation requirements for patients with a known or suspected infection.

As part of the inspection we asked for details of any infection control outbreaks that had occurred in this ward for the previous six months prior to our inspection. In this we can see that there had been two occasions where the ward had been closed to new admissions due to an infection outbreak and two occasions where a multi-bed bay was closed. In evidence submitted we can see that the infections were contained in either the medical side of the ward or the haematology/oncology section. No outbreaks affected both groups of patients.

The Healthcare Infection Incident Assessment Tool (HIIAT) should be used by the infection prevention and control team to assess every healthcare infection incident. It assesses the initial impact and monitors any ongoing impact of such an outbreak. As part of this inspection, we asked NHS Highland if all four incidents were captured on the HIIAT tool and reported to ARHAI. We were provided with evidence of the HIIAT tool being completed and reported to ARHAI in two of the incidents. NHS Highland have explained that the remaining two out of the four incidents were due to Covid-19, resulting in a single bay closure with no transmission out with the room and therefore did not require to be reported. Current guidance states incidents from key respiratory pathogens (COVID-19, influenza and respiratory syncytial virus (RSV)) should be reported to ARHAI using a separate 'Respiratory Short Form'. We were told that for one of these incidents, there was not a healthcare associated infection outbreak as there were not two or more linked cases. Instead, the multi-bed bay had been closed to enable closer monitoring. However, in the second incident, the process for completing a "Respiratory Short Form" was not followed. A requirement has been made to support improvement in this area.

We were provided with the minutes of the Problem Assessment Group in March 2024.This had been set up in response to one of the infection outbreaks and describes audits completed by the infection prevention and control team. These had identified sub-optimal compliance with standard infection control precautions and that the infection prevention and control team would provide additional staff training. NHS Highland provided evidence with the results of infection prevention and control audits of this ward from April 2024 to November 2024, covering areas such as hand hygiene, safe management of linen, patient placement and personal protective equipment use, which showed a compliance rate of 90% or more. Further evidence provided for this ward included training compliance rates for nursing staff in infection prevention and control modules, highlighting a compliance rate of 80% or more. During our inspection, inspectors observed good compliance with standard infection control precautions in this ward.

During our discussion session, senior managers explained that they had identified that having medical patients being cared for in the same ward area as haematology and

oncology patients was an area of concern for them. We were told that the risks of caring for both groups of patients in one ward was not captured on the risk register. In evidence provided to us we can see that the infection prevention and control team had highlighted the risks of using this ward for both groups of patients via various meetings and committees. These include the Incident Management Team meeting, the Acute Division Infection Control Committee and the Control of Infection Committee. We were told that it was challenging to find a suitable location for the 16 bed haematology and oncology unit.

In narrative submitted to us in evidence, senior managers have explained that these concerns were presented to the acute senior leadership team meeting early in December 2024. We were told that following this, a number of recommendations are due to be implemented including reducing the number of haematology and oncology beds from 16 to 14 to improve bed spacing in multi bed bays. This is due to be completed by the end of January 2025. It is important to highlight that inspectors observed that the 16 beds were appropriately spaced as per the national infection prevention and control manual. We were also told that from the end of December 2024, the additional patients being cared for in the ward would now be neurology rehabilitation patients. This is hoped to reduce the turnover of patients being cared for in this part of the ward and provide consistency as the substantive staff would also relocate from their current location.

In evidence returned to us, we observed that Raigmore Hospital have reported an increase in Clostridioides difficile cases prior to our inspection. Clostridioides difficile is a form of bacteria that can cause an infection of the colon. Symptoms can include diarrhoea, dehydration and nausea. In evidence returned to us, we observed that ARHAI were informed of these incidents. We were also provided with minutes from Problem Assessment Groups and Incident Team Meetings where incidents of Clostridioides difficile were discussed and involved senior members of the infection prevention and control team as well as senior nursing staff and medical staff. We were also told that a short life working group has been set up in response to the increase in cases. The membership of this group includes senior members of the infection prevention and control team for Raigmore Hospital. NHS Highland shared with us the minutes of the last meeting of this group where we can see that themes such as antibiotic prescribing and hand hygiene were identified and that the group were considering alternative methods of cleaning to reduce the incidence of infection. We were told that initiatives such as a staff education video had been developed to improve staff awareness. In patient safety incident reports submitted to us as part of evidence, we can see that staff were identifying and reporting patients with symptoms promptly and commencing treatment according to microbiology.

Areas of good practice

Domain 4.1	
8	Mealtimes were well organised and patients were supported with hand hygiene prior to meals.

Requirements

Domain 4.1	
2	NHS Highland must ensure all patients have access to a call bell.
3	NHS Highland must ensure all staff comply with hand hygiene and the correct use of Personal Protective Equipment.
4	NHS Highland must ensure that all staff comply with the safe storage of linen.
5	NHS Highland must ensure that all staff comply with safe sharps management.
6	NHS Highland must ensure that the hospital environment is maintained to facilitate effective cleaning.
7	NHS Highland must ensure cleaning products are stored safely and securely.
8	NHS Highland must ensure that a risk assessment is completed when prioritising patients for single room accommodation and that there are systems and processes for staff to monitor and escalate concerns regarding lack of available single room accommodation.
9	NHS Highland must ensure all healthcare infection incidents, including previously unreported incidents, are reported in line with guidance within the national infection prevention and control manual.

Domain 4.3 – Workforce planning

Quality 4.3 – Workforce planning

NHS Highland demonstrated strong support for newly qualified nurses and assistant practitioners. We were told of a high use of supplementary staff within certain clinical areas and observed compliance for mandatory training was low in some areas.

Workforce data submitted by NHS Highland demonstrated a current vacancy level of 4.7% within the band 5 nursing workforce during the time of our inspection. We consider a high vacancy rate to be over 10%. It appeared that some vacancies were adjusted to ensure more senior clinical nursing leadership as we can also see that band 6 and band 7 nursing posts were above established numbers.

Whilst we can see that Raigmore Hospital's nursing vacancy rate is below 10%, the prolonged use of a significant number of additional beds means that the current funded establishment is less than the workforce required. In one ward area using additional beds we observed a vacancy rate of over 40% for both registered nurses and healthcare support workers. This has resulted in the use of supplementary staff.

Supplementary staffing includes substantive staff working additional hours, staff from the NHS board's own staff bank or from an external agency. This was reflected in data returned as evidence and inspectors' observations during our onsite inspection. This included a ward area which had additional beds in use where staff told inspectors that the majority of staff on duty were supplementary staff.

We discussed this during our virtual discussion session with senior managers who had good oversight of the use of supplementary staff in these areas. We were told that there was work ongoing to review the substantive nursing establishment. In evidence submitted by NHS Highland, we observed that senior managers have raised quality and safety concerns in a briefing paper to the Executive Directors Group with regards to the continued use of supplementary staffing for the additional beds. These include compromised nurse-to-patient ratios, sometimes as low as one registered nurse to 15 patients overnight, and concerns that nursing teams are struggling to meet fundamental care needs such as timely medication administration and vital sign monitoring. Whilst we did not observe this during our inspection, this was reflected in patient feedback where some patients described waiting for up to half an hour for nursing staff to respond to requests for assistance.

In evidence submitted, we observed that senior managers have submitted proposals to increase the substantive nursing provision to cover an additional 42 beds to the Executive Director's Group in December 2024. NHS Highland have confirmed that both registered nursing and healthcare support worker vacancies have now been approved, the majority of which have already been advertised. It is expected that all posts will be recruited into by end of March 2025.

As described earlier in the report, we observed hospital safety huddles. We did not observe patient acuity discussed during the hospital wide huddle. Some staff that inspectors spoke with described frustration that staffing numbers did not reflect the acuity and dependency in clinical areas and did not feel confident that the appropriate skill mix was in place to deliver effective care. We discussed this with senior managers during our virtual discussion session who explained that patient acuity was captured in divisional huddles held prior to the hospital-wide huddle where staffing requirements are entered into an online spreadsheet called the "staffing sheet" and recorded. This was referred to as "Safe to start" process which supports identification of nursing staffing risks.

In evidence submitted to us, we were provided with a blank version of the "OPEL Staffing tool' which applied a risk scoring to a ward based upon nurse: patient ratios. There was no ability in this sheet to capture any increased patient dependency or acuity that may impact safe staffing levels. We were also provided with a completed version of the medical directorate's electronic staffing sheet for the first day of our onsite inspection. In this we observed that each ward within the directorate has both the day and night shift staffing completed with comments added where patients are requiring additional support such as enhanced observations. Patients may require

enhanced observations when more responsive and personalised care is provided to focus on prevention and early intervention of any potential risks. It was difficult to ascertain from this how robust the process is for reviewing and recording of patient acuity to support Professional Judgement as well as the recording of any mitigations to limit any identified staffing risks. A requirement has been given to support compliance with the Health and Care (Staffing) (Scotland) Act 2019.

In evidence provided we observed that the role of band 4 assistant practitioners has been introduced. Assistant practitioners work under the supervision of a registered practitioner to undertake care and treatment tasks and will develop a high level of skill through training and experience. We can see that NHS Highland have developed a programme that ward based assistant practitioners complete. This includes completion of the Scottish Vocational Qualification (SVQ) Healthcare Support (Clinical) at level 7 with additional modules at level 8. Assistant practitioners are also supported to spend time in various departments such as the flow team, physiotherapy, occupational therapy and theatres in order to gain understanding of a patient's journey throughout the hospital. We were also told that NHS Highland provide simulation training for assistant practitioners in areas such as recognising the deteriorating patient and communication skills. Senior managers also explained that assistant practitioners are supported to complete the Scottish Improvement Foundation Skills (SIFS) course where they will develop skills and knowledge in order to undertake improvement work in their clinical area.

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). The application of the common staffing method supports NHS boards to ensure appropriate staffing and the provision of safe and high quality care. From 1 April 2024, NHS boards are required to demonstrate that they are complying with the duties as cited in the legislation. Inspectors were told by some staff that they were aware that staffing level tool runs had been completed for their clinical area however, they did not always receive feedback from this. In evidence returned to us we were provided with the Quality Assurance checklist that staff complete following a tool run. This prompts staff completing the tool run to communicate the feedback of the tool with staff. We were told during our virtual discussion sessions that as the full process for completing the tool runs were not due for completion until the end of December 2024, it would be likely that staff would be unaware of the outcomes when talking to inspectors. NHS Highland have confirmed that all inpatient tool runs have now been completed and that discussion sessions have been held in December within the medical and surgical directorates. We were also told that a Common Staffing Methodology tool output workshop will be held in February 2025.

We were able to review completed tool runs for three areas in Raigmore Hospital. We observed data entry errors in the completed tool runs which we raised during our discussion session with senior managers. We were told that assurance processes were in place to minimise errors and they supplied us with the draft version of the

Application of Common Staffing Method and Staffing Level Tools standard operating procedure. Whilst this and the Quality Assurance checklist have been provided, we are not assured of the processes in place to support robust application of the Common Staffing Method. A requirement has been given to support improvement in this area.

Inspectors were told by staff in one clinical area that there was insufficiently trained staff to safely provide the systemic anti-cancer therapy (SACT) service. We raised this with senior managers who explained that presently 69% of nursing staff in the ward that this therapy is provided are trained in the administration of SACT and will rise to 75% by February 2025. The remaining staff are newly qualified and plans are in place to commence their training in September 2025. In addition, NHS Highland were able to provide evidence of additional staff in Raigmore Hospital that are SACT trained and able to support the ward where required. This included two acute oncology advanced nurse practitioners who commenced in December 2024. Senior managers explained that rosters are confirmed at least six weeks in advance and weekly SACT scheduling meetings allow managers to review staffing levels at this time. We were also told that the workforce tool will be run at least twice a year to ensure safe staffing levels for this clinical area are maintained.

Inspectors spoke with several senior charge nurses who described finding it challenging to access dedicated leadership time due to pressures within their clinical area. We heard that where there is pressure across the system this does impact directly on the ability to meet the requirements of the Health and Care (Staffing) (Scotland) Act 2019 regarding the ability of senior charge nurses to protect dedicated leadership time. We were provided with a draft version of the NHS Highland Time to Lead standard operating procedure which explains how this will be captured and monitored.

Under the requirements of the Health and Care (Staffing) (Scotland) Act 2019 there is a duty to release staff for training (Duty 12II). NHS Highland were able to provide us with evidence of good support for newly qualified nurses with the use of the Flying Start programme and a competency booklet. We were also told Clinical Educators work closely with teams to support learning and education.

In evidence submitted by NHS Highland we observed low compliance for some mandatory training such as moving and handling and violence and aggression training. We also observed in evidence provided that violence and aggression towards staff is one of the top themes in incident reports for Raigmore Hospital. One ward showed a significantly higher level of violence and aggression incidents compared to others in the same speciality. During our discussion session with senior managers we were told that work had been undertaken to review training offered to staff in regard to violence and aggression and that a risk-based approach now enables staff to receive training suitable for the role and work location. We were provided with the violence and aggression training compliance figures for wards within the surgical directorate. This showed that all wards had at least 50% of nursing staff trained. Senior managers also

recognised that due to clinical pressures it is difficult to release staff to training. A requirement has been given to support improvement in this area.

NHS Highland provided us with absence data for September 2024. In this we can see sickness absence for all grades of nursing staff was 6.7%. Predicted sickness absence allowance for workload tools is set at 4%. An absence of 6.7% can lead to a shortage of available staff. We were also able to review sickness data for some of the clinical areas we inspected, with one ward highlighting a sickness absence rate of 18.9%. In this area we also observed reduced staffing morale from the staffing survey I-matter. We were told that senior charge nurses receive support from Human Resources to complete review meetings for staff with a short or long term absence. We were also told staff will be offered support via NHS Scotland workforce policies. Staff can also receive support via the occupational health service, spiritual care team and peer support groups. As described earlier in the report, some clinical areas have developed their own bespoke support services such as the wellbeing room in ICU and the support service the emergency department offer following any potentially distressing situations.

NHS Highland were able to share with us plans for the 'Nursing Wellbeing Project at Raigmore', the aim of which is to increase wellbeing, resilience, recruitment and retention within the nursing workforce of Raigmore Hospital. Plans include leadership development for nursing staff working in senior leadership roles such as Senior Charge Nurse or Clinical Support Manager. It is anticipated that up to 60 members of staff will participate. Other initiatives funded through this project include a variety of training being delivered via virtual reality headsets and the development of 'Wellbeing Champions' who will receive additional training to enable them to support staff wellbeing in their clinical area. We were also told of plans to develop a dedicated space for staff to attend and relax as well as providing an area for staff to utilise when attending reflective practitioner settings.

Areas of good practice

Domain 4.3	
9	NHS Highland offer good support to newly qualified nurses and band 4 assistant practitioners.
10	Staff are supported to develop quality improvement projects.

Requirements

Domain 4.3	
10	NHS Highland must ensure appropriate staffing is in place that is reflective of the number and care needs of patients. This should include recording of clinical professional judgement of real-time staffing requirements, including evidence of how decisions are reached and communicated.
11	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.
12	NHS Highland must ensure all staff are able to access training required for their role.

Domain 6 – Dignity and respect

Quality 6.1 – Dignity and respect

We observed staff working hard to provide compassionate and responsive care and patients and relatives we spoke with were complimentary about staff and the care provided. However, some patients described a lack of accessible toilet and shower facilities.

The majority of patients inspectors spoke with described a high standard of care and acknowledged how busy staff were. Inspectors observed kind interactions between staff and patients throughout the hospital. However, some patients did voice that when staff are busy, they felt at times staff were less responsive. As described earlier in the report, in one ward some patients did not have call bells to hand due to them being placed out of easy reach.

In one ward, inspectors spoke with a family who raised concerns surrounding the use of bed rails for their relative who was a patient in the hospital. We raised this with the nurse in charge at the time of inspection who took time to reassure the patient's family and answer any questions. Inspectors observed that all documentation including a falls risk assessment and bed rail assessment were completed fully when reviewing the patient notes.

Inspectors observed that the critical care area of the hospital was accessed via a buzzer access system. This was clearly signposted and the button to exit the area is easily accessible. The senior charge nurse for the area explained that patients and their families found the high level of people moving through the unit intrusive and this had been put in place to protect patient dignity and privacy.

One patient we spoke with raised concerns of not being able to access the toilet in one of the wards due to the layout of the toilets not being accessible for patients with certain mobility issues. Instead of accessing the toilet, some patients with mobility issues described having to use a commode at their bedside which they found frustrating. This does not promote or support patient dignity. During our virtual discussion session, we were told by senior hospital managers that due to the age and layout of the building it was challenging to provide wheelchair accessible toilet and shower facilities in the majority of wards. However, there are accessible facilities available in the hospital. We were told that whilst there is no specific risk assessment to highlight patients that are unable to access showers, patients with mobility issues

that had prolonged admissions would be discussed at charge nurse or senior charge nurse levels. We are not assured that all patients can access suitable toilet and shower facilities to promote patient choice and dignity. A requirement has been given to support improvement in this area.

One of the wards inspected cared for patients who were medically fit to be discharged but were unable to do so due to other reasons such as not having a suitable package of care in place. Inspectors observed that there were a number of patients being cared for in this ward that had been in for a prolonged period of time. Inspectors observed that there were activities for patients advertised on a board within the ward however, many patients inspectors spoke to were unaware of these. We discussed this with senior managers during our discussion session who explained that the befriending service visit weekly as well as twice weekly visits from two therapy dogs called Bonnie and Red. Further activities include weekly afternoon teas and an available activities room with board and card games that families and friends of patients are encouraged to use. We were also told of future plans for meaningful activities including trike rides with a community group called Spokes for Folks and Ross County Football club working with the ward team to enable patients to attend games. The number of patients whose discharge is delayed impacts on the ability of a hospital to move patients through the hospital to the right care and treatment. Across NHS Scotland delayed discharges are now at the highest levels since July 2016. Whilst we recognise efforts being made by NHS Highland to support meaningful activities for this patient group, it is important to highlight that for those patients whose discharge is delayed they can experience poorer outcomes.

Areas of good practice

Domain 6	
11	We observed staff to be kind and caring.
12	Staff in Raigmore Hospital have developed a range of activities for patients to participate in whose discharge is delayed.

Requirement

Domain 6	
13	NHS Highland must ensure patient dignity is maintained at all times. This includes, but is not limited to, access to suitable toilet and shower facilities for patients requiring mobility aids.

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 - gov.scot (www.gov.scot) (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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