Healthcare Improvement Scotland

Care of Older People in Hospital

Standards

June 2015

Evidence

NHS SCOTLAND

Healthcare Improvement Scotland is committed to equality and diversity. We have assessed these standards for likely impact on the nine equality protected characteristics as stated in the Equality Act 2010 and defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. A copy of the impact assessment is available upon request from the Healthcare Improvement Scotland Equality and Diversity Advisor.

www.healthcareimprovementscotland.org

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About Healthcare Improvement Scotland

We believe that every person in Scotland should receive the best healthcare possible every time they come into contact with their health service.

We have a key role in supporting healthcare providers to make sure that their services meet these expectations and continually improve the healthcare the people of Scotland receive.

We are a public body and have four principle functions:

● providing sound evidence for improved healthcare, through the Scottish Medicines Consortium, the Scottish Health Technologies Group and the Scottish Intercollegiate Guidelines Network

● supporting the delivery of a safer health service and the reliable spread of best practice in quality improvement

● ensuring the effective participation of the public in the design and delivery of healthcare, principally through the Scottish Health Council, and

● scrutinising and quality assuring the provision of healthcare.

Our work programme supports the healthcare priorities of the Scottish Government, in particular those of NHSScotland's Healthcare Quality Strategy and the 2020 Vision.

For more information about our role, direction and priorities, please visit: www.healthcareimprovementscotland.org/drivingimprovement.aspx.

Background to the Care of Older People in Hospital Standards

The care of older people in hospital has been a focus in recent policy developments and improvement programmes.[1, 2] In November 2013, the Whittle Review Group[3] reported its findings and recommendations to strengthen the methodology underpinning Healthcare Improvement Scotland's inspections for care of older people in acute hospitals. In one of the recommendations, Healthcare Improvement Scotland was tasked with revising the *Clinical Standards for Older People in Acute Care* (2002).[4]

Scope of the standards

The revised standards support acute episodes of care of older people in hospital. The scope focuses on initial assessment after admission and on more complex journeys of care (rehabilitation, care transitions and discharge planning). The standards have been developed in recognition of the integration of health and social care services (for example, through setting criteria for multi-agency working in discharge planning). A summary of the main differences between the 2002 standards and the 2015 standards can be found in Appendix 1.

The standards are equally applicable to all patients using NHS services in Scotland with regard to protected characteristics under the Equality Act 2010, including age.[5]

Older people are the focus of these standards. However, the project group sought not to provide a definitive age cut-off point; treatment and care will be determined by a range of considerations, including functionality. It was not felt appropriate to state that these standards applied to all people aged over 65 or 75 years of age. Each patient will be assessed based on their individual needs and preferences, and not age alone. NHS boards will be asked to demonstrate processes for access to assessment, treatment and care, for example, comprehensive geriatric assessment and falls prevention, although in recognition of health inequalities across Scotland, this may vary by NHS board. As a consequence, the standards should be reviewed pragmatically by service providers: *not every criterion will apply to all older people in hospital.*

Standards 1 to 3 emphasise the overarching principles of person-centred care (involving older people, dignity, privacy, and decision-making) and should be applied throughout the patient journey, and across all standards.

Format of the standards

All our standards follow the same format. Each standard includes:

- a statement of the level of performance to be achieved
- a rationale providing reasons why the standard is considered important, and
- a list of criteria describing the structures, processes and outcomes.

The standards also identify what the standards mean for organisations and staff.

Within these standards, all criteria are considered to be 'essential' in order to demonstrate that the standard has been met.

Examples of how NHS boards can demonstrate achievement can be found at the

end of each standard.

Terminology

Wherever possible, we have incorporated generic terminology, which can be applied across all healthcare settings. The term 'patient' is used within the criteria to refer to the older person receiving acute care. The term 'representative' is used throughout the standards to refer to any person the patient wishes to be involved in their care. This includes, but is not limited to, carers, family, or independent advocates.

Information for patients and members of the public

It should be noted that this document has been developed to support staff to ensure the highest standards for the care of older people in hospital presenting with an acute episode, wherever healthcare is delivered. Each standard details what patients, their representatives and the public can expect of healthcare services in Scotland following implementation.

Implementation

Healthcare Improvement Scotland's three key organisational priorities are to:

- empower people to have an informed voice that maximises their impact in managing their own care and shaping how services are designed and delivered
- reliably spread and support implementation of best practice to improve healthcare, and
- comprehensively assess the quality and safety of healthcare.

Since April 2012, Healthcare Improvement Scotland has been leading a programme of national improvement support for older people in acute care.[2] This complements the ongoing programme of inspection for older people in acute hospital that was launched in 2011 at the request of Scottish Government to assess standards of care and enable NHS boards to identify areas for local improvement.

The improvement programme focuses on delirium and the identification and management of frailty. The identification and management of frail individuals and/or those individuals with delirium is complex and ensuring reliable processes are in place to support improved outcomes remains a key focus of our work.

A collaborative approach has been adopted to bring together healthcare teams from across Scotland to test changes, share and spread good practice, and provide improvement support.

Every acute hospital in Scotland has been inspected and areas of strength and areas for improvement highlighted. These standards will inform the inspection process along with the following standards:

- *Standards of Care for Dementia in Scotland*[6]
- *Standards for Food, Fluid and Nutritional care*[7]
- *Best Practice Statement for the Prevention and Management of Pressure Ulcers.*[8]

These standards should also be read alongside other national standards[9] and policy.[10-13]

Summary of standards

Standard 1   Older people in hospital have the opportunity and are enabled to discuss their needs and preferences, including the people they wish to be involved in their care.

Standard 2   Older people in hospital will be treated with dignity and privacy, particularly during communication, physical examination and activities of daily living.

Standard 3   Older people in hospital are involved in decisions about their care and treatment.

Standard 4   Older people have an initial assessment on admission to hospital, which identifies:

- their current health needs and any predisposing conditions which may heighten the risk of healthcare-associated harm, and

- where care and treatment can most appropriately be provided.

Standard 5   Older people presenting with frailty syndromes have prompt access to a comprehensive geriatric assessment and management by a specialist team.

Standard 6   Pharmaceutical care contributes to the safe provision of care for older people in hospital.

Standard 7   Older people in hospital have their cognitive status assessed and documented.

Standard 8   Older people in hospital experiencing an episode of delirium are assessed, treated and managed appropriately.

Standard 9   Older people in hospital with a confirmed or suspected diagnosis of dementia receive high quality care.

Standard 10   Older people in hospital with a confirmed or suspected diagnosis of depression receive care and have appropriate management and interventions put in place to minimise decline and contribute to quicker recovery.

Standard 11   Older people in hospital are assessed for their risk of falls within 24 hours of admission, and have appropriate measures put in place to reduce that risk.

Standard 12   Older people in hospital have access to rehabilitation services that are timely, accessible and person-centred.

Standard 13   Effective discharge planning is a continual process and starts as soon after admission as possible, or before admission for planned admissions. Communication, including transfer of information between healthcare and social care professionals, is essential to a seamless process of transition.

Standard 14   Older people in hospital are supported during periods of transition or delays between care environments through co-ordinated, person-centred and multi-agency planning.

Standard 15   Older people in hospital are cared for in the right place at the right time.

Standard 16   Older people in hospital are cared for by knowledgeable and skilled staff, with care provided at a safe staffing level.

Care of Older People in Hospital Standards

Standard 1: Involving older people: "What and who matters to me"

> **Standard statement**
>
> Older people in hospital have the opportunity and are enabled to discuss their needs and preferences, including the people they wish to be involved in their care.

Rationale

Person-centred care involves people and services working collaboratively and in equal partnership. Care provision that focuses on personal goals, preferences and needs, results in more effective care with better outcomes and experience for patients, and improved patient safety.[14-16]

The Patients Charter (2012)[17] and other initiatives[18,19] set out key principles and rights of people accessing healthcare, which include:

- discussing with patients their needs and preferences in relation to their care
- identifying the individuals who matter to the patient, for example their carer, family members, neighbours or spiritual advisor, and
- establishing the patient's communication needs and preferred methods of communication.

Criteria

1.1 Throughout their journey, older people in hospital have the opportunity:

(a) to say what and who matters to them

(b) are supported to ensure this is achieved, and

(c) have this regularly reviewed.

1.2 Older people in hospital are assessed to ensure their communication and sensory needs are met.

1.3 The patient's representative is involved where the patient has difficulties in communicating what and who matters to them.

1.4 Information about what and who matters to the patient is used in all care and treatment plans, provides the basis for shared decision-making, and:
(a) informs the setting and reviewing of personal goals and outcomes

(b) is regularly reviewed by the multidisciplinary team, and

(c) informs handovers, care transitions and discharge planning.

What does the standard mean for older people in hospital?

Patients have the opportunity to involve their carers, families and/or other representatives in their care. Patients can expect to be treated as an individual in their care and treatment.

What does the standard mean for the organisation?

The organisation has systems and processes in place to ensure that the patients' needs and preferences are incorporated in their care and treatment.

What does the standard mean for staff?

Staff can actively:

- engage with patients to understand their needs and preferences, and
- seek information on who patients wish to be involved in their care.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*

Practical examples

- Ensuring patients have their glasses or hearing aids are available and functioning.
- Evidence of support for patients in communicating needs, for example interpreter services, independent advocacy services.
- Access to alternative information formats, for example Braille, other languages.
- Initiatives to maximise support from carers and relatives, for example extended visiting hours, access to telehealth, point of contact with a member of staff.
- Initiatives to enhance person-centred approaches, for example "Must Do With Me"[19] or "Getting to Know Me".
- Care plans demonstrating involvement of patients including incorporating their needs and preferences, for example facilitation of rapid discharge for people wishing to die at home.

Standard 2: Maintaining patient dignity and privacy

Standard statement

Older people in hospital will be treated with dignity and privacy, particularly during communication, physical examination and activities of daily living.

Rationale

A dignified and person-centred approach is of importance at all times. Privacy and dignity must be maintained as much as the patient's illness or functional limitations allow.[15-17] In particular, dignity and privacy is maximised during:[20]

- activities of daily living which are normally very private such as using the toilet, bathing, oral healthcare[21], and dressing

- eating and drinking

- intimate clinical examinations or procedures

- conversations around care and treatment particularly those of a sensitive nature

- interactions with patients using respectful language, and

- end of life care, for example privacy for saying goodbyes to families and friends.[22]

Criteria

2.1 A patient's preferences around dignity and privacy during sensitive conversations and activities of their daily living are sought, documented, actioned and shared with the multidisciplinary team, as required.

2.2 Staff are competent in providing and supporting effective communication, and demonstrate a dignified person-centred approach.

What does the standard mean for older people in hospital?
Every patient has the right to be treated with dignity, and their privacy is respected.
What does the standard mean for the organisation?
The organisation ensures that patients are treated with dignity, and their privacy respected.
What does the standard mean for staff?
Staff are familiar with and demonstrate a person-centred approach, ensuring that patient confidentiality is maintained.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*

Practical examples

- Person-centred initiatives and improvement work around dignity and privacy can be demonstrated.[23]

- Patient experience in relation to privacy, dignity and communication, and evidence of learning from complaints or feedback.

- Evidence of policies or processes to support patient privacy and dignity, for example chaperone policy.

- The availability of equipment and rooms to support privacy and dignity, for example single rooms for patients at the end of life.

- Evidence of staff training, learning and competency in effective communication and person-centred approaches such as Conversation Ready[24], Making Communication Better[25], promoting continence.[64]

Standard 3: Decision-making, consent and capacity

Standard statement

Older people in hospital are involved in decisions about their care and treatment.

Rationale

All people receiving healthcare have a right to be involved in decisions about their care and treatment.[17, 26, 27] Age must not be the basis for excluding people from services and interventions.[5]

For older people in hospital, there are a number of areas for discussion and decision-making, including:

- treatment decisions, particularly treatment requiring formal written consent
- anticipatory care planning
- care and treatment towards the end of life,[28] including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)[29, 30] decisions and preferred place of death, and
- discharge from hospital to preferred place of care (for example, care homes).

Capacity for decision-making must be assessed in line with the Adults with Incapacity (Scotland) Act 2000[31] and as capacity may fluctuate over the course of an inpatient stay, this is regularly reviewed. The patient's representative should be included in discussions around capacity, where consent has been provided by the patient.

Discussions can often be sensitive and complex, and should be undertaken by experienced health and social care staff. Any discussions or decisions about care or treatment should be documented in the healthcare record and made readily accessible to patients, their representatives and staff.

Criteria

3.1   Patients will not be excluded from services, treatment or care on the basis of age.

3.2   Patients will not be excluded from services, treatment or care on the grounds of cognitive impairment.

3.3   Patients (and/or representatives) are involved in all discussions and decision-making relating to their care and treatment, and healthcare records clearly document:

(a) who the patient has consented to being involved in discussions and decision-making

(b) who has been involved in the decision-making process

(c) what information has been provided to the patient (and/or representative)

(d) the treatment options and alternatives available to the patient, and

(e) the patient's decision.

3.4 The patient's capacity for decision-making relating to their care and treatment, is assessed, regularly reviewed and documented, where clinically indicated.

3.5 For patients assessed as not having capacity to make decisions, the principles of the Adults with Incapacity (Scotland) Act 2000 are applied as follows:

(a) patients are supported to express their opinion and make a decision as much as they are able to

(b) proxy decision-makers (for example, welfare attorneys) are consulted regarding the patient's proposed care and treatment, and

(c) the healthcare records document capacity assessment and contain copies of a Certificate of Incapacity and Power of Attorney orders.

What does the standard mean for older people in hospital?
Every patient has the right to be involved in discussions about their care and treatment.
What does the standard mean for the organisation?
The organisation has systems and processes in place for ensuring that patients are involved in decision-making, and have their capacity for consent assessed where appropriate.
What does the standard mean for staff?
Staff will understand their roles and responsibilities in supporting patients to make decisions, and in assessing and documenting capacity to consent.
Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Care plans demonstrating involvement of patients in decision-making, including incorporating their needs and preferences, for example facilitating rapid discharge for people wishing to die at home. • Feedback from patients and/or representatives on their experience of care. • Provision of access to support services to enable decision-making, for example independent advocacy services, interpreter services. • Evidence in care plans of capacity assessment, including copies of Certificate 47 or power of attorney order for patients lacking capacity. • Evidence of compliance with the principles of relevant legislation.[5, 31] • Evidence of staff training and education in consent and capacity assessment. • Evidence of implementation of national guidance, including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy.[30]

Standard 4: Initial assessment on admission to hospital

Standard statement

Older people have an initial assessment on admission to hospital, which identifies:

- their current health needs and any predisposing conditions which may heighten the risk of healthcare associated harm, and
- where care and treatment can most appropriately be provided.

Rationale

Older people frequently have complex healthcare needs as a result of a higher prevalence of multi-morbidity, physical and cognitive impairment.[32] Older people who are frail or who have cognitive impairment, including delirium, are at particular risk of healthcare-associated harm.[14]

At first presentation to hospital care (for example, elective admission and pre-assessment clinics, and unscheduled care, such as accident and emergency or medical admission units), the aim of the initial assessment is to identify:

- all health problems contributing to their presentation including current and predisposing conditions, for example, palliative or end of life care needs, cognitive impairment, and
- where care is best provided balancing the risks and benefits of inpatient care or care within the community, for example the person's home or care home.

Criteria

4.1 The initial assessment identifies opportunities to deliver care in community settings where clinically appropriate. Care plans are developed to allow care to be transitioned to community-based teams with specialist knowledge and skills.

4.2 A multidisciplinary care plan is developed and reviewed with the patient (and/or representatives), and includes:

   (a) results of initial and subsequent assessments, for example, comprehensive geriatric assessment, hip fracture pathways, initiation of pathways for the deteriorating patient.

   (b) results of medicines review, including ability to self-manage medication

   (c) planned frequency and dates for care plan reviews, and

   (d) actions to be taken as part of the review.

4.3 Staff can access additional patient information, such as advanced care plans, anticipatory care plans or the key information summary, where this is available.

4.4 Assessments will be repeated during an acute episode of care when there has been a change in the health status of the patient.

What does the standard mean for older people in hospital?
Patients are assessed for the care and treatment they need and where care is best provided for them.
What does the standard mean for the organisation?
The organisation ensures that systems and pathways are in place for the rapid assessment of older people presenting to hospital.
What does the standard mean for staff?
Staff are trained and knowledgeable, relevant to their role and responsibilities, in assessing the needs of older people admitted to hospital, and are able to access the most appropriate care for their needs.
Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Local implementation of pathways and policies during the initial assessment such as *Care of Deteriorating Patients*[33], *Standards for Hip Fracture*[9]*, Scottish Palliative Care End of Life Care Guidelines*[22] and comprehensive geriatric assessment.[32] • Protocols or pathways supporting care transition to community teams and settings. • Care plans demonstrating outcomes from initial assessment, including medicines review. • Care plans demonstrating access and using anticipatory care plans or key information summary.

Standard 5: Comprehensive geriatric assessment

Standard statement

Older people presenting with frailty syndromes have prompt access to a comprehensive geriatric assessment and management by a specialist team.

Rationale

Frailty has been defined as a "decreased ability to withstand illness without loss of function".[34] Older people often present with 'frailty syndromes': falls, immobility, confusion, incontinence and functional decline.[32]

A comprehensive geriatric assessment is a multidisciplinary assessment which aids identification of frailty syndromes and care planning for frail older people in hospital, and improves patient outcomes.[35, 36] It is recommended that a comprehensive geriatric assessment is initiated within 24 hours of admission.[32]

When inpatient care is required, there is evidence that patient outcomes are better when older people with frailty syndromes are cared for on dedicated specialist geriatric medicine wards within 24 hours of need identified. However, if the patient's main need is for another specialist area of support (for example, oncology or orthopaedics, palliative care, general surgery), the patient should be referred to that specialty.

Criteria

5.1 A comprehensive geriatric assessment is initiated within 24 hours of admission to hospital by suitably skilled staff for patients presenting with frailty syndromes. Where a CGA is not clinically appropriate, this will be documented in the patient's healthcare record.

5.2 Patients with frailty syndromes reach a specialist geriatric bed within 24 hours of admission.

5.3 Patients with frailty syndromes who require other specialist input (for example, orthopaedics, oncology, palliative care or general surgery), reach the appropriate bed within 24 hours of admission.

5.4 Staff can provide evidence that they have the appropriate experience, specialist knowledge and skills in undertaking comprehensive geriatric assessment.

5.5 Organisations can demonstrate timely access to comprehensive geriatric assessment, specialist beds and teams that are monitored, reviewed and remedial action is taken as appropriate.

What does the standard mean for older people in hospital?

Patients with frailty syndromes can expect a comprehensive geriatric assessment to be initiated quickly and their treatment reviewed by a multidisciplinary team.

What does the standard mean for the organisation?
The organisation ensures that: • systems and processes are in place to support access to a comprehensive geriatric assessment, specialist beds and teams • staff providing care in non-specialist areas have the skills and knowledge to undertake a comprehensive geriatric assessment.
What does the standard mean for staff?
Staff can: • understand their roles and responsibilities in relation to the initiation of a comprehensive geriatric assessment pathway and accessing specialist teams, and • maintain their knowledge and skills in frailty syndromes and comprehensive geriatric assessment.
Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Data to support compliance with comprehensive geriatric assessment and access to specialist beds within 24 hours of admission. • Referral protocols or pathways for assessment and management of frailty syndromes. • Evidence of staff training and education in comprehensive geriatric assessment and frailty syndromes. • Evidence supporting implementation of improvement work, such as Think Frailty.[32] • Evidence of how remote and rural NHS boards access specialist knowledge and skills, for example to deliver comprehensive geriatric assessment. • Range of services provided or accessed, such as number of people accessing hospital at home service.

Standard 6: Pharmaceutical care

Standard statement

Pharmaceutical care contributes to the safe provision of the care for older people in hospital.

Rationale

Pharmaceutical care is a key component of safe and effective healthcare. It involves a model of pharmacy practice which requires pharmacists to work in partnership with patients (and/or representatives) and other health and social care professionals to obtain optimal outcomes from treatment with medicines and eliminate adverse events whenever possible.[37] This is particularly important for patients with complex health issues, including multi-morbidities.[38]

Medication is a common intervention for older people so it is important to ensure that the patients' ability to manage their medicines safely is assessed. As they may require (or be prescribed) a complex combination of medicines, older people are at a higher risk of adverse effects.[39]

Covert medication describes the administration of medicines in disguised form, for example hidden in food or drink, which is likely to occur when a person refuses to take medication necessary for their physical or mental health. The decision to supply medicines covertly should be taken with consideration of necessity, a person's capacity for decision-making, and preferences or wishes. Covert medication must never be given to someone who is capable of deciding about their medical treatment.[40]

Criteria

6.1 There is effective communication with the patient (and/or representatives) about the multidisciplinary care plan, which includes any medication changes, and the long term medication plan when transferring to and from all settings.

6.2 Medicines reconciliation is undertaken within 24 hours of admission and at discharge.

6.3 The multidisciplinary team assesses the patient's (and/or representatives) ability to manage their medicines safely, including **before** discharge.

6.4 At the point of discharge, the patient (and/or representatives) will receive the correct medicines and information to support taking them appropriately.

6.5 The multidisciplinary team will ensure support and monitoring of medicines for patients who require this after discharge.

6.6 National polypharmacy guidelines are implemented.

6.7 A proactive clinical pharmacy service is available and supports medicines reconciliation, review and compliance assessment.

What does the standard mean for older people in hospital?

Patients receive the right medicines, with appropriate levels of support and information to enable them to self-manage their medicines safely.

What does the standard mean for the organisation?

The organisation ensures:

- systems and processes are in place to provide governance of pharmaceutical care, and

- implementation of national polypharmacy guidance.[37]

What does the standard mean for staff?

Staff involved in the prescribing, supply and administration of medicines are:

- aware of their roles and responsibilities in pharmaceutical care

- trained and knowledgeable in pharmaceutical care relevant to their roles and responsibilities.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*

Practical examples

- Availability of patient and carer information.

- Assessing the patient's ability to self-manage their medicines safely.

- Evidence supporting the implementation of guidance such as national polypharmacy guidance[37], *Prescription for Excellence*[38]*, Scottish Palliative Care Guidelines.*[22]

- Medicines reviews including reconciliation and covert medication.

- Evidence supporting the implementation of improvement work.

- Local protocols and policies, for example mental welfare.

Standard 7: Assessment and prevention of decline in cognition

Standard statement

Older people in hospital have their cognitive status assessed and documented.

Rationale

Cognitive functioning can have a significant impact on an older person's health and wellbeing. Acute changes or fluctuation in cognition and function may reflect delirium[41], effects of medication or other underlying medical problems requiring investigation and management. Assessment should also include history of any acute changes to usual cognition and function from the patient and/or representatives.[32, 42]

Cognition is assessed, where appropriate or clinically indicated, giving the patient the best chance of performing well, for example by ensuring that the patient's glasses or hearing aids are available and in working order, and undertaking the assessment in a quiet environment and at a time when the patient appears to be less cognitively compromised.

The length of hospital stay for the older person can be reduced by maximising function and taking proactive measures to prevent further decline in cognitive impairment.

Criteria

7.1   A cognitive assessment is undertaken at initial assessment, or where clinically indicated, and documented in the patient's healthcare record.

7.2   As part of the cognitive assessment, acute changes to usual cognitive status are identified and confirmed by the patient and/or representative.

7.3   Any previous diagnosis of dementia, delirium or depression are confirmed and inform care and treatment.

7.4   Wards caring for patients with cognitive impairment or delirium:

   (a) have appropriate lighting and noise levels for the time of day

   (b) provide information that aids communication, for example large signage

   (c) actively encourage the patient's representatives to visit, and be involved with the patient's care if they usually do so, and

   (d) promote healthy sleep and encourage a normal sleep pattern.

What does the standard mean for older people in hospital?
Patients requiring a cognitive assessment will receive this in a timely manner by trained staff and acute changes in cognition will be treated.
What does the standard mean for the organisation?
The organisation will ensure that systems and processes are in place, including staff training and education, to assess cognition rapidly and accurately.

What does the standard mean for staff?
Staff will have an understanding of cognitive functioning and decline prevention, and where appropriate, will be trained to undertake cognitive assessments.
Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Utilisation of locally validated cognitive assessment tools, for example 4AT.[42] • Pathways for initiating cognitive assessment as part of initial assessment. • Evidence of environmental considerations, for example dementia-friendly wards. • Use of patient and representative information on delirium.

Standard 8: Delirium

Standard statement

Older people in hospital experiencing an episode of delirium are assessed, treated and managed appropriately.

Rationale

Delirium is common in hospitalised older people, particularly those with dementia or cognitive impairment, and is associated with a variety of adverse outcomes. Delirium represents an acute dysfunction of the brain and often has multiple causes. Optimal management of delirium relies on prompt diagnosis and comprehensive assessment, as delirium is often neither diagnosed nor treated appropriately.[41, 42, 43]

Support should also be provided to reduce distress experienced by people affected by delirium and their representatives.[44]

Criteria

8.1 Patients with a diagnosis of delirium have common causes of delirium considered and documented, and their management and progress reviewed by the multidisciplinary team.

8.2 If, during comprehensive geriatric assessment, a new cognitive abnormality or a sudden change in cognition is identified, the patient will be assessed for delirium.

8.3 Monitoring for delirium will continue until the patient is either cognitively settled, delirium is confirmed, or an alternative diagnosis is confirmed.

8.4 Capacity to consent to treatment is assessed and documented for patients for whom delirium is ongoing after initial treatment.

8.5 Staff, and the patient's representative, are made aware when a patient has been diagnosed with delirium.

What does the standard mean for older people in hospital?
Patients with suspected delirium are rapidly assessed, diagnosed and treated.
What does the standard mean for the organisation?
The organisation has systems and processes in place to support the assessment and management of delirium, including staff training and education.
What does the standard mean for staff?
Staff can: • demonstrate knowledge and competence in the assessment and management of delirium, and • support patients (and/or representatives) experiencing distress.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*

Practical examples

- Delirium assessment and management tools, for example 4AT or TIME bundle.[41]

- Supportive measures and information for patients with delirium and their representatives.

- Protocols or pathways for the management of delirium, including communication with the multidisciplinary team.

- Evidence of compliance with the capacity assessment process.

- Evidence of training and education in the assessment and management of delirium.[45]

- Feedback on patient (and/or representative) on their experience of care.

- Evidence of provision of ward environment suitable for patients with delirium.

Standard 9: Dementia

Standard statement

Older people in hospital with a confirmed or suspected diagnosis of dementia receive high quality care.

Rationale

Many older people with dementia are admitted to hospital for assessment and treatment. They are at an increased risk of developing complications such as delirium, infection, malnutrition, dehydration, constipation and falls.[46, 47]

As part of the *National Dementia Strategy*[48], the Scottish Government with NHS boards and integration partnerships have agreed to the *10 Care Actions* to support the implementation of the *Standards of Care for Dementia in Scotland*[6]*,* in hospitals.

Criteria

9.1 Patients with a diagnosis of dementia have this documented together with their baseline level of cognition and function, and current care and support provision on admission to hospital.

9.2 Patients with dementia receive high quality care in hospital which reflects current best practice such as the *Standards of Care for Dementia in Scotland* and *the 10 Care Actions.*

9.3 When a new diagnosis of dementia is suspected and depending on symptoms and severity, patients are referred:

(a) to the specialist older people mental health liaison team during admission, and

(b) for post-discharge follow-up by either a community mental health team for older people or a primary care team.

What does the standard mean for older people in hospital?
Patients with dementia experience high quality hospital care which meets their individual needs and preferences.
What does the standard mean for the organisation?
The organisation ensures that systems and processes are in place to support the care of patients with dementia in line with the *Standards of Care for Dementia in Scotland and the 10 Care Actions*.
What does the standard mean for staff?
Staff are trained in the assessment and management of dementia relevant to their roles and responsibilities.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Evidence of action plans for the implementation of *Standards of Care for Dementia in Scotland* and the *10 Care Actions*.[6, 48] • Evidence of improvement work, for example dementia friendly environments, dementia champions, *Promoting Excellence Framework*[49], Promoting Continence.[64] • Referral protocols and pathways to specialist teams.

Standard 10: Depression

Standard statement

Older people in hospital with a confirmed or suspected diagnosis of depression receive care and have appropriate management and interventions put in place to minimise decline and contribute to quicker recovery.

Rationale

Depression is not a normal or inevitable consequence of the ageing process. Depression is prevalent in older people admitted to hospital and is often under-recognised, including by the person affected themselves, and inadequately treated.[50] Depression in older people can present itself in different ways, including increased physical complaints, irritability or anger and more demanding behaviour.

Assessment tools can be used to identify depression in older people, help evaluate the clinical severity of depression, and monitor treatment. Failure to address psychological illness hinders rehabilitation and leads to unnecessarily poorer outcomes.[50]

Criteria

10.1   Patients with a confirmed or preliminary diagnosis of depression on admission, including those with a primary diagnosis of dementia, have this documented.

10.2   If assessment indicates possible depression, this is documented and a care plan agreed.

10.3   Patients in hospital with a diagnosis of depression (confirmed or suspected) are referred to:

(a) a specialist older people mental health liaison team (if input is required during admission)

(b) a community mental health team for older people or a primary care team on discharge, or

(c) condition-specific specialists.

What does the standard mean for older people in hospital?
Patients with depression receive an assessment, management and treatment tailored to their needs.
What does the standard mean for the organisation?
The organisation ensures that systems and processes are in place for the assessment, management and treatment of depression in older people.

What does the standard mean for staff?

Staff are aware of:

- their roles and responsibilities in relation to the assessment and management of depression in older people, and

- local referral processes to specialist or community teams.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*

Practical examples

- Referral protocols and pathways to older people's mental health teams or equivalent.
- Demonstration of adequately resourced services for older people including psychological therapies.
- Evidence of staff training and education in the assessment, management and treatment of depression in older people.

Standard 11: Falls prevention management

Standard statement

Older people in hospital are assessed for their risk of falls within 24 hours of admission, and appropriate measures put in place to reduce that risk.

Rationale

Many older people in hospital have been admitted because of mobility problems or as a result of injury from falls. In-hospital falls are estimated to occur at a rate of three to five falls per 1,000 occupied bed days in acute hospitals, with higher rates in areas such as elderly care.[51] A comprehensive geriatric assessment will identify factors which may have contributed to the falls and establish evidence-based interventions to maintain the safety of the patient while they are in hospital and after discharge. A systematic review highlighted that multi-factorial interventions (including post-falls reviews) may reduce falls rates by between 18 to 31% in hospitals.[51]

While the patient may have been identified at risk of falls, it remains important to encourage a culture of enabling, recovery and rehabilitation to maximise independence.[52]

Criteria

11.1 A falls risk assessment is initiated within 24 hours of admission.

11.2 Patients with identified falls risk factors have a care plan for meeting those needs or mitigating those risks which:

(a) is developed with the patient (and/or representative)

(b) is shared in an appropriate format, and

(c) includes a medicines review.

11.3 A clear falls prevention plan is documented and shared with the multidisciplinary team on discharge or transition between care settings.

11.4 Staff can deliver safe and effective falls prevention and management.

11.5 Clear process and protocols are in place for the organisation to review, record, share information and monitor all falls in hospital.

What does the standard mean for older people in hospital?
Patients can expect to be cared for in an environment that will monitor, minimise and manage falls.
What does the standard mean for the organisation?
The organisation has a falls policy and strategic plan to manage risk from falls, and prevent falls in hospital.
What does the standard mean for staff?
Staff are trained and knowledgeable in falls risk assessment and prevention.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*

Practical examples

- Evidence of care plans demonstrating falls risk assessments and planned outcomes.
- Policies or strategic plans relating to falls management and prevention, including post-falls protocols.
- Data and associated action plans relating to number of falls and incident reporting.
- Evidence supporting local improvement work relating to falls prevention, for example SPSP falls bundle, *Scottish Standards of Care for Hip Fracture*.[9, 51]
- Evidence of staff training and education on fall prevention and management.
- Referral pathways for rehabilitation and enablement within community settings.

Standard 12: Rehabilitation

Standard statement

Older people in hospital have access to rehabilitation services that are timely, accessible and person-centred.

Rationale

Some patients cannot be discharged directly home when treatment of their initial clinical condition is complete and may require further multidisciplinary rehabilitation. Rehabilitation while in hospital can reduce dependency and length of stay, and increase the probability of a successful discharge.[53, 54]

Goal-setting can enhance the patient's experience of rehabilitation, improve engagement in the rehabilitation process and improve recovery, and should be developed with the patient and their representatives where agreed.

Intermediate care services provide a package of focused, intensive, time-limited interventions commonly provided in the home or a community setting. For some patients, rehabilitation may be undertaken in a hospital ward until they are medically ready for transfer to another setting, for example rehabilitation facility, intermediate care or home.

Rehabilitation plans are developed, which take into account required equipment and adaptations, particularly for the home environment.[55] Delays or lack of access to equipment can put the patient at risk, hinder rehabilitation and delay discharge.

Criteria

12.1   A multidisciplinary rehabilitation plan is developed with the patient (and/or representative), and includes:

(a) goals and outcomes that are specific, measurable, achievable, realistic and timed (SMART)

(b) details of support for the patient (and/or representative) to maintain their skills and function in hospital while they wait for discharge, and

(c) regular reviews and updates of agreed goals and outcomes.

12.2   The patient receives a rehabilitation plan, which is delivered in a timely manner and in an appropriate setting for the patient.

12.3   Rehabilitation is carried out by a multidisciplinary team who are trained and skilled in delivering rehabilitation, enablement and developing personal goals and personal outcomes.

12.4   The organisation can provide evidence of how rehabilitation services are delivered including:

(a) rapid provision of equipment for example, equipment or adaptations to the patient's home (including care homes), and

(b) availability of alternative facilities to a hospital ward (including their home or homely setting) for the older person to receive their rehabilitation, where it is clinically appropriate and safe to do so.

What does the standard mean for older people in hospital?
Patients have the opportunity to participate in decisions about their rehabilitation plan. The rehabilitation plan will maximise their chance of returning home or to a community setting.
What does the standard mean for the organisation?
The organisation provides well-organised and adequately resourced rehabilitation services.
What does the standard mean for staff?
Staff are trained in rehabilitation of older people, including joint goal-setting.
Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Patient healthcare records detailing rehabilitation goals and outcomes. • Communication between health and social care providers detailing rehabilitation plans. • Referral pathways and protocols for rehabilitation services, adaptations and equipment services. • Arrangements to provide multidisciplinary rehabilitation and enablement services, for example 7-day rehabilitation service, alternative facilities to hospital wards or telecare.

Standard 13: Pre-discharge planning

Standard statement

Effective discharge planning is a continual process and starts as soon after admission as possible, or before admission for planned admissions. Communication, including transfer of information between healthcare and social care professionals, is essential to a seamless process of transition.

Rationale

Effective discharge management facilitates the timely discharge of patients and aims to provide necessary support, follow-up and rehabilitation in the community, whilst preventing further decline or relapse and subsequent need for readmission.[56, 57] Pre-discharge planning is particularly important for older people with cognitive impairment. Before leaving hospital, the patient's diagnosis should be clearly communicated to the primary care team and follow-up arrangements to perform or complete assessments should be in place. For patients who are at the end of their life and wish to die at home or in a homely setting, rapid discharge should be facilitated and supported.

Regardless of discharge setting or diagnosis, a person-centred, multidisciplinary and multiagency discharge plan is developed, followed and reviewed with the patient (and/or representative), and includes:

- medicines review and reconciliation[58]

- information around anticipatory care planning

- any further referral, support and treatment identified is agreed, documented and shared with all relevant agencies, and

- clear communication with the patient (and/or representatives) and all agencies involved, for example primary care, social care and third sector.

Criteria

13.1 A multidisciplinary discharge plan is developed with the patient, including those with cognitive impairment (and/or representatives), and includes:

(a) details of specialist assessments (for example, a comprehensive geriatric assessment) and outcomes

(b) details of future care plans and/or referrals to specialist, community or primary care, and

(c) consent obtained from those with power of attorney or legal guardians where a patient does not have capacity.

13.2 The patient's representative is involved in discharge planning with the patient's consent and can access carer advice and support if required.

13.3 For new episodes of cognitive impairment or depression identified during admission, the diagnosis and any residual symptoms are clearly documented on the discharge letter and communicated to the patient (and/or representative), the primary care team, and any condition specific specialist teams for appropriate follow-up.

13.4 The immediate discharge letter is sent to the GP within five working days of the patient's discharge.

13.5 Primary care and other health and social care community teams are informed of discharge plan.

What does the standard mean for older people in hospital?
Patients are discharged from hospital in a timely and co-ordinated way.
What does the standard mean for the organisation?
The organisation has systems and processes in place for integrated discharge planning.
What does the standard mean for staff?
Staff follow local protocols for discharge planning and ensure all relevant people are informed.
Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples   • Evidence of use of multidisciplinary discharge checklists or templates, for example, *Scottish Intercollegiate Guidelines Network Guideline 128.*[57]   • Evidence of improvement audit relating to discharge planning and actions plans.   • Care plans detailing discharge plans that demonstrate, for example, communication between health and social care providers, patient and/or representative involvement in discharge planning, transportation arrangements, rehabilitation plans.   • Referral pathways and protocols supporting discharge, such as facilitating early discharge for people nearing end of life and wishing to die at home.   • Patient and/or representative feedback relating to discharge.

Standard 14: Care transitions

Standard statement

Older people in hospital are supported during periods of transition or delays between care environments through co-ordinated, person-centred and multi-agency planning.

Rationale

Well co-ordinated care and support of older people returning home or to a homely setting (such as care homes) from hospital has been shown to improve discharge management and improve patient experience.[59]

As part of care transition, including planned admissions, there is robust planning and communication between the patient, their representatives and multidisciplinary teams. Standards relating to patient pathways and flow apply equally to care transitions to home or homely settings.

Criteria

14.1   There is a co-ordinated person-centred approach to care transitions for older people in hospital, which includes the patient's representative where appropriate.

14.2   Effectiveness is monitored in terms of patient (and/or representative) experience as well as service impact.

14.3   The patient will have access to a health or social care member of staff who is responsible for co-ordinating their transition back to the community in collaboration with all relevant agencies.

14.4   The care and support needs of patients who are delayed from hospital discharge are reviewed weekly.

What does the standard mean for older people in hospital?
Patients can expect care transitions that are co-ordinated and person-centred.
What does the standard mean for the organisation?
The organisation has systems and processes in place for effective care transition management.
What does the standard mean for staff?
Staff play a key role in ensuring good communication and transition planning.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Multidisciplinary or multi-agency care transition planning, for example team huddles and virtual wards. • Data relating to delayed discharges and evidence of action plans. • Process for delayed discharge management. • Feedback and/or complaints from patients (and/or representatives) relating to delayed discharge and care transitions. • Evidence of processes which support care transitions for people with complex needs, for example dementia or end of life.

Standard 15: Patient pathway and flow

Standard statement

Older people in hospital are cared for in the right place at the right time.

Rationale

Patient safety is intrinsically linked to effective patient flow. Flow is described as 'the movement of patients, information or equipment between departments, staff groups or organisations as part of a patient's care pathway.[60] This is especially true for frail older people, and for people with complex needs, such as dementia, cognitive impairment or palliative and end of life care needs. Transfer policies, specifying the transfer of information and appropriate equipment, which promote continuity of patient care are a marker of quality of care.

Older patients are more likely to have adverse outcomes, including increased mortality, longer stay in hospital and poorer patient experience, when they are inappropriately moved in hospital (for example, at night or multiple moves) or when discharge is delayed. Boarding is when a patient's care and treatment are delivered in hospital areas that are not designed to meet their care needs.[61]

Criteria

15.1 Boarding of any patient is minimised.

15.2 Arrangements are in place to improve flow for older people to ensure that the right patient is cared for in the right way, in the right place at the right time.

15.3 Systems and processes are in place to minimise the potential patient safety risks and poorer outcomes associated with patients not being cared for in the right place.

15.4 Organisations demonstrate adherence to transfer policies to ensure that hospital moves add value for patient care and are due to clinical need and not service pressures.

15.5 Patients with cognitive impairment are not moved to another bed, room or ward unless clinically necessary for their treatment or to manage clinical risks.

15.6 If, after multidisciplinary team agreement, the patient is moved, the reason for the move is clearly documented and shared with the patient (and/or their representative).

What does the standard mean for older people in hospital?
Patients transfer between departments is minimised and based on clinical need.
What does the standard mean for the organisation?
The organisation has systems and processes in place to effectively manage patient flow, including information and equipment.

What does the standard mean for staff?
Staff are aware of the need to avoid boarding or inappropriate moves for older people in hospital.
Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*
Practical examples • Evidence of data on boarding and protocols or processes for the management of boarding. • Evidence of action log for learning and improvement in the management of patient flow. • Evidence of the review and monitoring of the appropriate care provision by ward, including beds, equipment and staffing levels for the care of older people • Protocols for transfer of patients between departments, transfer to community settings (care homes, hospital at home) and boarding. • Evidence of care plans documenting decisions for patient transfers or reasons for boarding.

Standard 16: Skills mix and staffing levels

Standard statement

Older people are cared for by knowledgeable and skilled staff, with care provided at a safe staffing level.

Rationale

Good care requires a holistic, integrated, multidisciplinary approach delivered by a knowledgeable, well-trained, compassionate team of professionals and support staff. Training and education may include, but is not limited to, areas such as communication skills, cognitive impairment[45], dementia[49], and palliative and end of life care.[62]

Safe care in hospitals can only be delivered when the team has safe staffing levels, supported by the appropriate skills mix for the patient population and the right attitude and approach to care.[63]

Criteria

16.1 Training in the knowledge and skills to care for older people in hospital is available to all staff, including support staff.

16.2 Staff demonstrate the knowledge, skills and competencies necessary within their role for the delivery of safe and effective care for older people, including awareness of carer involvement.

16.3 Staff who care for people with cognitive impairment or dementia are trained in line with the *Promoting Excellence* framework.

16.4 Staff training is available for the identification and management of depression in older people.

16.5 There are clear processes in place to demonstrate safe staffing levels with the appropriate skills mix.

16.6 For nursing staff, workforce planning tools are implemented.

16.7 There are clear processes in place for staff to escalate any concerns about staffing levels and there are associated plans to mitigate safety risk.

16.8 There are processes in place for the monitoring of multidisciplinary staffing levels and skills mix.

16.9 Professional accountability for senior clinical decision-making is clear and is complemented by clinical leadership, supervision and support for staff.

What does the standard mean for older people in hospital?
Patients are assured that staff are educated and trained in delivering care for older people in hospital and use their learning to ensure care that is safe, effective and person-centred.

What does the standard mean for the organisation?

The organisation has systems and processes in place to:

- assess the capacity and capability of older people's services to deliver quality improvement work, with a clear plan of how patient safety improvement work will be implemented, and
- demonstrate that knowledge and competency of staff involved in the care of older people in hospital is maintained.

What does the standard mean for staff?

Staff can demonstrate knowledge and competence in delivery of the care of older people in hospital that is safe, effective and person-centred.

Examples of evidence of achievement *(NOTE: this list is not exhaustive.)*

Practical examples

- Action plan for implementing quality improvement work relating to the care of older people in hospital.
- Evidence of staff education and training in quality improvement methodology relevant to their role and responsibilities.
- Whistleblowing policy for staff concerned about staffing levels.
- Workforce plans to determine staffing levels in relation to dependency and continuity plans to manage staffing shortages.

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Appendix 1: Summary of changes to the 2002 standards

2002 topics/standards	2015 topics/standards
Standard 1: The option to remain at home	• Initial assessment on admission to hospital (Standard 4)
Standard 2: Assessment of Older People being admitted briefly *Standard 3: Older people admitted for inpatient acute care*	• Initial assessment on admission to hospital (Standard 4) • Comprehensive geriatric assessment (Standard 5) • Assessment and prevention of decline in cognition (Standard 7) • Also covered in: Delirium (Standard 8), Dementia (Standard 9), Depression (Standard 10)
Standard 4: Rehabilitation in Acute Care Wards	• Rehabilitation (Standard 12)
Standard 5: Discharge management	• Pre-discharge planning (Standard 13) • Care transitions (Standard 14) • Also covered in Involving older people (Standard 1), Pharmaceutical care (Standard 6)
Standard 6: Equipment and adaptations	No longer a separate standard, but contained in: • Rehabilitation (Standard 12) • Pre-discharge planning (Standard 13) • Patient pathway and flow (Standard 15)
Standard 7: Hip fracture	No longer included in the standards and replaced Falls prevention management (Standard 11).
Standard 8: Communication between the Trust and Older People	Emphasised throughout the standards and contained in: • Involving older people (Standard 1) • Maintaining patient dignity and privacy (Standard 2) • Decision-making, consent and capacity (Standard 3)
Standard 9: Communication between the Trust and other agencies that provide care for Older People	• Pharmaceutical care (Standard 6) • Rehabilitation (Standard 12) • Pre-discharge planning (Standard 13) • Patient pathway and flow (Standard 15)
	New standards • Pharmaceutical care (Standard 6) • Skills mix and staffing levels (Standard 16) • Falls prevention management (Standard 11)

Appendix 2: Development of the standards

Background

The revised standards are based on previous clinical standards, *Older People in Acute Care* (2002) and build on current evidence and practice. These 2015 standards supersede the 2002 version.

A project group, chaired by Dr Christine McAlpine (Geriatric Medicine Specialty Advisor to the Chief Medical Officer) was convened in January 2014 to consider the 2002 standards, related policy and guidance, and to identify key themes for standards development. Subgroups were established to take this work forward under relevant themes.

Project group membership

Dr Christine McAlpine (Chair)	*Geriatric Medicine Specialty Advisor to the Chief Medical Officer, NHS Greater Glasgow and Clyde*
Ms Penny Bond	*Implementation and Improvement Support Team Leader, Healthcare Improvement Scotland*
Dr Arun Chaudhuri	*Consultant Acute Physician, NHS Tayside*
Dr Robert Flowerdew	*Faculty Member, Royal College of General Practitioners*
Ms Karen Goudie	*National Clinical Lead, National Improving Older People's Care in Acute Care, Healthcare Improvement Scotland*
Dr Graeme Hoyle	*Consultant Geriatrician, NHS Grampian*
Ms Ellen Hudson	*Associate Director Professional Practice, Royal College of Nursing Scotland*
Dr Matt Lambert	*Clinical Lecturer and Specialty Registrar in Medicine for Elderly and Stroke, NHS Tayside*
Dr Fiona Macleod	*Consultant Clinical Psychologist, Lead Clinician - Older People Psychological Therapies Service, NHS Tayside*
Ms Trudi Marshall	*Nurse Consultant, NHS Lanarkshire*
Ms Carolyn McDonald	*Associate Director Allied Health Professionals, NHS Fife*
Ms Alison McGruther	*Unit Nurse Manager, Elderly and Rehabilitation Services, NHS Grampian*
Dr Brian McGurn	*Consultant Geriatrician, NHS Lanarkshire*
Dr Martin McKechnie	*Chair of the College of Emergency Medicine Scotland, NHS Lothian*
Dr Alan McKenzie	*Consultant Geriatrician and Secretary and Treasurer, British Geriatrics Society (Scotland), NHS Forth Valley*
Mr James McWilliams	*Senior Nurse Quality and Projects, NHS Lothian*

Ms Audrey Melrose	*Alzheimer Scotland Nurse Consultant for Dementia, NHS Forth Valley*
Mr Jimmy Myles	*Lead Nurse Acute Care, NHS Western Isles*
Ms Elaine Peace	*Director of Nursing, Midwifery and Allied Health Professionals, NHS Orkney*
Mr Jim Pearson	*Deputy Director of Policy, Alzheimer Scotland*
Ms Irene Robertson	*Inspector, Healthcare Improvement Scotland*
Dr Cesar Rodriguez	*Associate Medical Director (Older People), Consultant in Old Age Psychiatry, NHS Tayside*
Mr Ian Smith	*Senior Inspector, Healthcare Improvement Scotland*
Mr Garry Todd	*Principal Pharmacist, NHS Lothian*
Ms Lesley Yarrow	*Allied Health Professionals Consultant, Older People's Service, NHS Forth Valley*
Mr Derek Young	*Policy Officer, Age Scotland*

Consultation and peer review

Specialist review

A project reference group was established to undertake peer review of the document before consultation and publication. The reference group included representatives from the Whittle Review Group.[3]

Ms Chris Beech	*Nurse Consultant - Services for Older People, NHS Forth Valley*
Ms Elaine Burt	*Head of Nursing for Rehabilitation and Assessment, NHS Greater Glasgow and Clyde*
Dr Anne Hendry	*National Clinical Lead for Integrated Care Joint Improvement Team, Scottish Government*
Dr Sarah Keir	*Consultant Stroke Physician, Medicine of the Elderly, NHS Lothian*
Dr Douglas Lowdon	*Consultant, Acute and Elderly Medicine, NHS Tayside*
Ms Fiona Mackenzie	*Professional Advisor, Directorate for Chief Nursing Officer, Scottish Government*
Professor Alasdair MacLullich	*Professor of Geriatric Medicine, University of Edinburgh*
Mr Shaun Maher	*Improvement Advisor, Healthcare Improvement Scotland*
Mr Hugh Masters	*Associate Chief Nursing Officer, Scottish Government*

Dr Seamus McNulty	*Chair of the Old Age Psychiatry Faculty, Royal College of Psychiatrists*
Ms Helen Paterson	*Associate Director of Nursing, NHS Forth Valley*
Ms Kathryn Paterson	*Associate Improvement Advisor, Healthcare Improvement Scotland*
Dr Terry Quinn	*Clinical Lecturer in Geriatric Medicine, University of Glasgow*
Ms Sandra Shields	*Nurse Consultant for Dementia, NHS Greater Glasgow and Clyde*
Ms Vicky Thompson	*Professional Advisor, Directorate for Chief Nursing Officer*
Dr Rowan Wallace	*Consultant Geriatrician, NHS Ayrshire & Arran*

Consultation

We contacted professional bodies and independent healthcare organisations and healthcare and social care professionals involved in care of older people, requesting feedback using a variety of methods, including:

- the Healthcare Improvement Scotland website
- a feedback form provided with the distributed draft standards, and
- a public partnership forum.

Following the publication of the draft standards for *Care of Older People in Hospital* in November 2014, we held a 6-week consultation period and used a wide range of methods to capture comments and feedback.

During the consultation period, 1,345 comments were received from a variety of stakeholders. All comments on the draft standards were presented to the project group. Each comment was considered and responded to by the project group. This consultation feedback report includes all comments received, together with the project group's response and any subsequent amendments to the standards. All comments have been anonymised.

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