Healthcare Improvement Scotland | Evidence
Advice, guidance and intelligence

Ageing and frailty

Draft standards for the care of older people

NHS SCOTLAND

We are committed to advancing equality, promoting diversity and championing human rights. These standards are intended to enhance improvements in health and social care for everyone, regardless of their age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socioeconomic status or any other status. Suggested aspects to consider and recommended practice throughout these standards should be interpreted as being inclusive of everyone living in Scotland.

We carried out an equality impact assessment (EQIA) to help us consider if everyone accessing health and social care services will experience the intended benefits of these standards in a fair and equitable way. A copy of the EQIA is available on request.

Healthcare Improvement Scotland is committed to ensuring that our standards are up-to-date, fit for purpose and informed by high quality evidence and best practice. We consistently assess the validity of our standards, working with partners across health and social care, the third sector and those with lived and living experience. We encourage you to contact the standards and indicators team at his.standardsandindicators@nhs.scot to notify us of any updates that might require consideration.

Healthcare Improvement Scotland Year

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Introduction

These standards update and replace Healthcare Improvement Scotland's Standards of Care for Older People in Hospital (2015). The new standards will apply in all settings where frail older people receive health and social care. They provide a benchmark for progress towards nationally consistent integrated frailty services that put people and their rights at the centre.

Frailty

When a person is living with frailty, their body systems are gradually losing their in-built reserves, leaving them vulnerable to significant changes in their health or circumstances. They can experience difficulty recovering from an injury, infection or illness.[1] People with frailty are likely to experience falls, immobility, delirium, incontinence and susceptibility to side effects of medication.[2, 3] As a person's frailty increases, they may find it more difficult to live independently and may require additional support and care.[4] People with frailty have an increased risk of admission to hospital.[5] Disability may also lead to reduced functional ability, but this does not automatically equate to frailty.

Older people who also live with frailty are amongst the most vulnerable in our society. They can be at risk of harm if we do not understand and address their needs, or if our systems and services are inadequate, ineffective or poorly coordinated. Frailty is not an inevitable consequence of ageing and many people live well into their 80s and 90s without ever being frail. Younger people living with disability may have reduced function, but this does not automatically equate to frailty. Coordinated multiagency care supports and enables people experiencing frailty to remain as independent as possible. If a person is living with frailty, or is at risk of frailty, it can sometimes be prevented, reversed or slowed down.

Who the standards are for

While frailty can be experienced at any age, these standards are for people who experience frailty associated with ageing. The United Nations define an older person as someone above the age of 60. In the UK, 65 is traditionally used as the marker for the start of chronological older age. **Biological ageing** refers to the changes to an individual person's body and mind that occur over time. While chronological age cannot be modified, biological ageing can be impacted by a range of factors. These include a person's socioeconomic circumstances and lifestyle and any long-term health conditions and comorbidities,.[3] A person's biological age can better help predict how frailty may develop and impact them.[6] This approach supports Realistic Medicine and shared decision making.

These standards are for people who are both older and frail and who are most likely to benefit from integrated, multiagency planning and delivery of care.

Aims

The overall aim of these standards is to ensure national consistency in the quality of care that people receive. The standards aim to support national improvements in the care of older people with frailty.

These standards further aim to promote positive, healthy and active ageing. In line with the principles of Realistic Medicine, the standards are underpinned by the following key principles:

- services should have a focus on prevention and early intervention
- people's choices and what matters to them should be at the centre of discussions
- interventions should be the least intrusive or restrictive possible.

In meeting the standards, organisations will ensure that people:

- have the care and support they need to maximise enjoyment of life
- have choice, autonomy and ownership of their life
- experience a palliative care approach that helps them to live well with deteriorating health
- work in partnership to make decisions about their health and care based on what matters to them.

Policy context

Standards are underpinned by human rights and seek to provide better outcomes for older people with frailty. The United Nations Principles for Older Persons were adopted by the UN General Assembly (Resolution 46/91) on 16 December 1991. Governments are encouraged to incorporate them into their national programmes whenever possible. The 18 principles, can be grouped under five themes: independence, participation, care, self-fulfilment and dignity.[7]

The ageing and frailty standards should be read alongside:

- Health and social care standards: my support, my life[8]
- International Covenant on Economic, Social and Cultural Rights[9]
- United Nations Convention on the Elimination of Discrimination Against Women[10]
- United Nations Convention on the Rights of Disabled People[11]

- General Comment No. 22 from the UN Committee on Economic, Social and Cultural Rights[12]
- Realistic Medicine – doing the right thing (2023)[13]
- Adults with Incapacity (Scotland) Act 2000[14]
- My Health, My Care, My Home – healthcare framework for adults living in care homes (2022)[15]
- Health and Care (Staffing) (Scotland) Act (2019)[16]
- Palliative care strategy (2024)[17]
- Dementia Strategy – Dementia in Scotland: Everyone's Story (2023)[18]
- Health and Social care: data strategy (2023)[19]
- Discovering meaning, purpose and hope through person centred wellbeing and spiritual care: framework.[20]
- Getting it right for everyone principles (GIRFE).[21]

Implementation

The Healthcare Improvement Scotland Quality Management System (QMS) Framework supports health and social care organisations to apply a consistent and coordinated approach to the management of the quality of health and care services. By using standards as part of a quality management system, organisations can work in partnership to develop learning, plan improvement and understand their whole system. Central to this is the relationship between people, their care partners and organisations.

Healthcare Improvement Scotland leads national improvement work focussing on frailty. In 2022, we published the findings of a 90-day learning cycle on frailty. This involved a review of the published literature on frailty and interviews with people with lived experience as well as health and social care professionals specialising in frailty. The report described the seven core components of an integrated frailty system.

Following this, we launched the Focus on Frailty improvement and implementation programme. The programme aims to improve the early identification and assessment of frailty with a view to improving access to person-centred and coordinated health and social care services. We also host a national frailty learning system with over 1,200 members. Through the learning system, members share practice examples, tools and resources relating to frailty improvement work. For further information about the network, please contact his.acutecare@nhs.scot.

The ageing and frailty standards will support the spread of person-centred approaches to care and support for people living with frailty. The standards will also support improvements to the early identification and assessment of frailty.

HIS may use these standards in a range of assurance and inspection activities. They may be used to review the quality and registration, where appropriate, of health and social care services.

Format of the standards

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

- an overarching standard statement
- a rationale explaining why the standard is important
- a list of criteria describing what is needed to meet the standard
- what the standard means if you are a person living with frailty
- what the standard means if you are a member of staff
- what the standard means for organisations
- examples of what meeting the standard looks like in practice.

Terminology

Wherever possible, we have used generic terminology which can be applied across all health and social care settings. The terms 'people', 'person' or 'individual' are used within the criteria to refer to the person receiving care or support.

The term **care partner** refers to any person or representative the individual wishes to be involved in their care. Care partners are generally unpaid carers who provide or intend to provide care for an individual.[22]

The term **family** refers to a person's life partner, siblings, parents, foster carers, kinship carers, adoptive families and extended family.

Staff refers to people who are employed to provide health and care support to an individual. It includes those defined in the Health and Care (Staffing) (Scotland) Act 2019.[16]

Palliative care is an approach that improves the quality of life of people, and their families, who are living with one or more advanced or progressive health conditions. It prevents and relieves suffering through the early identification, correct assessment and holistic management of pain and other problems, whether physical, mental, social or spiritual.

Future care planning involves conversations between individuals, their care partners and health or social care staff. It is an ongoing process that helps people talk about what matters to them in their lives, including if their health or care should change. Future care planning also gives people opportunities to discuss realistic options for treatment and care so they have a personalised future care plan that can be recorded, shared and reviewed.

Organisation refers to all health and social care providers or services that support older people with frailty. It includes NHS boards, social care providers, third sector and independent care providers.

How to participate in the consultation process

We welcome feedback on the draft standards and will review every comment received. We are using different methods of consultation, including:

- online and face-to face engagement
- meeting and event attendance to raise awareness and hear feedback
- an online survey: https://www.smartsurvey.co.uk/s/4SH8OS/

Submitting your comments

Responses to the draft standards should be submitted using our online survey: https://www.smartsurvey.co.uk/s/4SH8OS/.

The consultation closes on **18 June**. If you would like to submit your comments using a different format, please contact the project team on his.standardsandindicators@nhs.scot.

Consultation feedback

At the end of the consultation period, all comments will be collated and the Standards Development Group will create a response to each comment received on the draft standards. The response will explain how the comments were taken into account in producing the final standards.

A summary of the responses to the consultation will be made available on request from the project team at his.standardsandindicators@nhs.scot.

The final standards will be published in November 2024.

Summary of standards

Standard 1: Service design

Organisations demonstrate effective integration of frailty services and embed continuous system-wide improvement.

Standard 2: Identification and assessment

Organisations have systems in place to identify, assess and plan for the needs of older people with frailty at the earliest opportunity.

Standard 3: Person-led care coordination and future care planning

People are at the centre of their care and are actively involved in decisions related to care coordination and future care planning.

Standard 4: Support for staff and care partners

Staff and care partners are valued, supported and trained.

Standard 5: Keeping active

Older people with frailty are supported to keep active to maintain and improve mobility, independence and function.

Standard 6: Nutrition and hydration

Older people with frailty have their nutritional and hydration needs identified and met.

Standard 7: Medicines management

Older people with frailty are supported to discuss and understand the benefits, risks and alternatives of medicines and their medicines are regularly reviewed.

Standard 8: Living and dying well

People's wellbeing and enjoyment of older age is maximised and they are enabled to live well until the end of their life.

Standard 9: Care in hospital

Frail older people in hospital receive equitable, compassionate and safe care that promotes wellbeing and reduces the risk of harm.

Standard 10: Delirium, dementia and cognition

Older people experiencing a change in their cognition or mental state are identified, understood and supported.

Standard 11: Mental health

Older people with frailty have their mental health assessed and supported.

Standard 1: Service design

Standard statement

Organisations demonstrate effective integration of frailty services and embed continuous system-wide improvement.

Rationale

Older people use health and social care services more than any other population group. It is essential that these services are developed with the needs of older people in mind. Older people with frailty should be central to how services are designed, coordinated and delivered. Organisations should demonstrate their commitment to Getting it right for Everyone (GIRFE) through service design, coordination and delivery. This includes designing services in collaboration with older people with frailty.

Organisations should have a shared vision for healthy ageing and for preventing and managing frailty. [23] Effective integration requires a fundamental shift in culture towards preventative, rights-based, integrated services. [8, 24, 25] The aims, vision and outcomes of a service or organisation should focus on the needs and rights of people. This includes the right to visits from a care partner. Information should be shared in line with national protocols to support multiagency working.[4]

A quality management system can support services to embed continuous quality improvement.[18-20] High quality data should be used to measure improvement in outcomes that matter to people.

Digital technology, including artificial intelligence, can help identify and manage frailty. [26] As organisations evolve, they should ensure that use of new technology is effective and ethical.[27, 28] This includes artificial intelligence, wearable technology and digital information systems. [19, 29-31] Technology should be used within the principles of informed consent and person-centred care.

Criteria

1.1 Organisations have a clear, system-wide strategic vision for the integrated delivery of services for older people with frailty that embeds the principles of GIRFE.

1.2 Organisations work to a jointly-agreed multiagency delivery plan for integrated frailty services.

1.3 Organisations engage and involve older people as equal partners in:

- the codesign of services
- delivery of services
- monitoring the impact of services.

1.4 Organisations implement a quality management system to:

- plan and measure improvement in the care of older people with frailty
- develop evidence-based practice
- monitor and implement innovative practice
- share learning across the whole system.

1.5 Information gained from frailty assessments is recorded and shared with appropriate professionals and agencies across the health and social care system.

1.6 Staff can view relevant real-time clinical and social care information, including:

- pharmaceutical reviews and prescriptions
- care plans
- social work support assessments
- rehabilitation plans
- future care planning discussions
- adult support and protection concerns, where appropriate.

1.7 Organisations complete a workforce needs analysis to identify safe staffing levels for their population and implement a plan to meet national guidance.[32]

1.8 Organisations have policies and processes in place, including regular visits from a person's care partner, when isolation and quarantine are needed.

1.9 Organisations have processes in place for meaningful engagement with care partners to continuously improve support and communication across the whole system.

1.10 Organisations demonstrate ethical use of technology, including wearable technology, within the principles of informed consent and relevant legislation and guidance.

What does the standard mean for people?
• The system is designed around you and with you. • You can be confident that services are working together for you. • Your feedback and experiences are sought, valued and acted on. • Your rights underpin an effective, joined-up system.

What does the standard mean for staff?
Staff: • work across the whole system to support people with frailty • work towards a common goal and vision • put people's rights at the centre of their work.
What does the standard mean for the organisation?
Organisations: • work in partnership to support older people with frailty across the whole system • have processes in place to share information across services and organisations to support integrated care • can demonstrate their implementation of the Health and care Staffing Act (2021) in line with national guidance • ensure rights are upheld • design services in partnership with people who use them • collate and monitor data relevant to people with frailty • use data and feedback to measure improvement.
Examples of what meeting this standard might look like
• Public engagement strategy and mechanisms for codesign. • Future workforce plans in line with safe staffing legislation and guidance. • Information sharing agreements. • Routine data monitoring and development of a learning system. • Policies and transparency re: wearable tech, cameras etc. • Board or service champions for older people and frailty. • Audits for ethical decision making.

Standard 2: Identification and assessment

Standard statement

Organisations have systems in place to identify, assess and plan for the needs of older people with frailty at the earliest opportunity.

Rationale

Identifying frailty enables people to receive care in the right place at the right time. Once identified, people with frailty can be offered evidence-based interventions. Early identification supports future care planning and care around death. This includes discussions about preventative measures, medications and appropriate care.[23, 33]

Screening tools may be used to identify older people with frailty. The selection of tools should reflect the service, setting and population. Large-scale identification of frailty can be used to plan data-informed services at a strategic level.

People with frailty should have access to further assessment in order to identify their needs, any reversible causes or any modifiable risk factors that might cause them harm in the future. Assessments of frailty should be holistic, exploring physical, cognitive, functional, social, spiritual and psychological domains. [33] They should be relevant to the individual and take into account personal choices, circumstances and context.

For some people, referral to Comprehensive Geriatric Assessment (CGA) may be appropriate. CGA is a multidimensional, multidisciplinary process that identifies medical, social and functional needs. It can support people to stay at home for longer.

Assessments should be repeated when there are changes in health or social care needs or when the person is dying. People and their care partners should be part of discussions at all stages.

Identifying any care partners at this time may also be hugely beneficial. Early referrals can be made to appropriate support and planning including advice on how to prepare an Adult Carer Support Plan.

Criteria

2.1 Organisations demonstrate the use of systematic approaches to:

- identify the prevalence and characteristics of frailty in their population
- use data to inform strategic planning, including workforce planning
- implement effective prevention and healthy active ageing policies.

2.2 Organisations proactively identify frailty in older people who are:

- admitted to hospital
- at risk of frailty due to individual circumstances or care setting
- being considered for specialist care (such as elective surgery).

2.3 Organisations identify frailty using an approach that is:

- based on current evidence
- validated or recommended by professional organisations
- relevant to the care setting.

2.4 Staff identify where effective prevention and early support may reduce a person's risk of developing frailty.

2.5 People who have been identified as having frailty can access, as required:

- a comprehensive, holistic assessment of their care needs relevant to the setting
- timely, coordinated and ongoing support
- services and adaptations appropriate to their needs
- input from specialist services and multidisciplinary support
- investigations and diagnostics to determine underlying causes.

2.6 Care partners of older people with frailty:

- are identified as part of initial screening and assessments
- have a support plan in place where appropriate.

What does the standard mean for people?
• Staff will talk to you and people close to you about how you are feeling and managing in your daily activities. • Assessments of your health, care and support will focus on what matters to you and what you would like to be able to do. • You will be offered care and support that is right for you as early as possible. • Your care partner(s) will be identified and supported as early as possible.

What does the standard mean for staff?

Staff:

- proactively recognise and identify frailty in the people they care for
- undertake relevant frailty assessments and investigations where frailty has been identified
- use information from frailty assessments to identify needs, balance risks and benefits of treatments and plan for the future
- identify care partners.

What does the standard mean for the organisation?

Organisations:

- ensure screening for frailty is routinely undertaken amongst relevant population groups
- ensure patients identified as frail are offered appropriate assessments
- have processes and protocols for CGA for people being admitted to hospital
- ensure information about a diagnosis of frailty and any subsequent assessments are shared appropriately.

Examples of what meeting this standard might look like

- System-wide use of clinical risk stratification, frailty scores and electronic Frailty Index (eFI) in relevant settings.
- Data on frailty prevalence featuring in strategic commissioning plans and informing strategic decision making.
- Implementation of a universal referral process for frailty.
- National forums for raising awareness of frailty and how to identify it.
- Percentage of CGAs undertaken in relevant populations.
- Improvement in frailty scores following early community identification and intervention.
- Reduction in avoidable attendance to emergency departments following early identification and intervention.
- Evidence of frailty assessments informing future care planning.
- Identification flowcharts and decision making tools based on screening outcomes.

Standard 3: Person-led care coordination and future care planning

Standard statement

People are at the centre of their care and are actively involved in decisions related to care coordination and future care planning.

Rationale

People should receive the care they need from the right people at the right time. [34] When professionals work together, people experience better outcomes. Staff should coordinate referrals, people's movement between services or places of care, follow-up and review. They should meet a person's changing needs and circumstances.[35] A comprehensive and holistic assessment of the person's needs and preferences should begin at an early stage. Staff should have the information they need about a person to provide effective care. Communication between care providers should include appropriate documented information.

People need to have access to information to be part of discussions about their health and care. This includes information about frailty assessments and what may happen in the future. Identifying and meeting people's support needs enables people to play an active part in these discussions. This includes hearing, sensory and communication needs.

Future care helps people talk about what matters to them. It gives them opportunities to consider realistic, available options and helps them plan for future changes in their health and care. People should have the opportunity to review their future care plan as their condition or personal circumstances change.

Under the Carers (Scotland) Act 2016, care partners have a right to be involved in decisions relating to a person's health, care and future.[22]

Criteria

3.1 People are central in all decisions made about their health, care and future.

3.2 People are informed about their rights and how they will be upheld.

3.3 People have timely access to understandable and relevant information to enable them to participate in health and care decisions that affect them.

3.4 People are:

- asked about what and who matters to them
- supported to set and review personal goals and outcomes
- supported to take part in shared decision making.

3.5 People are fully informed about what to expect in a particular place of care, including information about the physical environment, any assessments taking place, the results of tests and what may happen next.

3.6 A multidisciplinary plan is developed and reviewed in partnership with the person. It includes:

- details of the lead coordinating organisation and individual
- roles and responsibilities of individuals and organisations
- results of initial and subsequent assessments
- results of medicines reviews, including ability to self-manage medication
- the results of assessments and outcomes if a person has attended hospital
- details of onward referrals or community support if a person is being discharged from hospital.

3.7 People are central to the development of a future care plan that includes:

- information about who and what matters to the person
- options for realistic treatments and care that are of overall benefit to the person
- plans for holistic care around death when the person is dying
- specific decisions about interventions and treatments, including resuscitation.

3.8 Care plans, including future care plans:

- involve discussions with care partners, where appropriate
- are shared with primary care and other health and social care community teams as appropriate
- meet relevant professional standards and national guidance.

3.9 When a person is dying, this is recognised and shared with relevant health and care professionals to ensure they are comfortable, safe, in the right place at that time and with those who matter to them.

3.10 Care partners are fully involved in discussions about care arrangements, treatment, interventions or future care planning where appropriate.

What does the standard mean for people?
• You have access to information about your health and your care. • You will have opportunities to discuss who and what matters to you. • You will be supported to understand what is happening with your care. • You will have the opportunity to ask questions about what may happen in the future. • Your care partners can be included in discussions about you and your care. • Information about your care will be written into a plan that will be shared with you and people who need it.
What does the standard mean for staff?
Staff: • consider a person's experiences, values and priorities at all stages of care planning • recognise the importance of autonomy and the right of the individual to make informed decisions about their care • include any care partners in discussions about a person's care as appropriate • work effectively with other members of the multidisciplinary team to coordinate care • have training and skills to lead conversations about future care planning.
What does the standard mean for the organisation?
Organisations: • ensure people are cared for in the right place at the right time • provide effective mechanisms to support multiagency working • have processes and protocols to share information in line with best practice • integrate future care planning with other care coordination and person-centred care • involve care partners in care coordination and future care planning where appropriate.

Examples of what meeting this standard might look like
• Decision support tools. • Integrated single care plans, digital care plans, use of technology to transfer information. • Key information summaries or clinical information shared as appropriate with multidisciplinary teams. • Future care plans recorded, shared and reviewed. • Assessment and identification protocols and procedures. • Accessible documentation in a range of languages and formats • Use of communication aids and tools. • Use of tools and frameworks to support shared decision making. • Feedback from people and care partners on their experience of communication.

Standard 4: Support for staff and care partners

Standard statement

Staff and care partners are valued, supported and trained.

Rationale

Skilled, trained and confident staff ensure that services are delivered to meet the needs of people who use them. Staff should understand their role and be supported within multidisciplinary teams. All staff, including care at home staff and paid carers, should receive ongoing accredited training and support appropriate to their roles and responsibilities. Services should ensure both appropriate numbers of staff and appropriate staff mix to meet the needs of their population.[16]

Care partners may require additional support as carers. They should be valued and supported for the role that they do and receive information or training as required. Section 1 of the 2016 Carers (Scotland) Act 2016 defines a 'carer' as an adult or child who provides or intends to provide care for another individual (unless that care is part of a contract or volunteering). Carers have a right to a support plan or Young Carers' Statement according to local eligibility criteria. Support should be holistic, tailored and preventative.[22]

Criteria

4.1 Staff and care partners are:

- valued and respected
- trusted to make good decisions
- included in decision making where appropriate
- able to raise concerns about safety or when shared care is not working.

4.2 Organisations provide access and time for continuing professional development for staff caring for older people.

4.3 Organisations deliver training in risk enablement for staff to:

- promote mobility and meaningful activity
- prevent deconditioning
- maximise choice, autonomy and quality of life.

4.4 Organisations provide care partners with access to, as required:

- practical support to continue providing care
- information specific to caring and their rights
- adult or young carer support plans
- short breaks from caring
- information and signposting for financial support.

4.5 Care partners are:

- able to access practical training, education and support, including peer support
- informed about independent advocacy and how to access it
- empowered and involved in all care settings to continue providing care if they choose.

4.6 Care partners know the mechanisms available to raise concerns about a person's care or support and, if these are not satisfactorily addressed, can access an independent complaints process.

4.7 Organisations provide training and time for staff to undertake assessments of frailty appropriate to their roles and responsibilities.

4.8 Staff are fully informed about their roles and responsibilities within the frailty pathway, the meaning of frailty assessments or screening and how to act on the results.

4.9 Staff can identify, understand and communicate with people who experience:

- cognitive impairment
- communication difficulties such as dysarthria and dysphasia
- hearing or sensory loss
- emotional distress.

4.10 Staff receive training appropriate to their roles and responsibilities about adult support and protection including:

- patterns of abuse and coercive control
- identification of an adult at risk of harm
- local safeguarding protocols and processes.

4.11 Staff are supported to put innovation and improvement into practice.

4.12 Staff have an individual wellbeing support plan.

4.13 Staff and care partners receive support and information related to anticipatory grief, grief and bereavement support.[36]

4.14 Staff can access bereavement support when impacted by loss in their workplace.

What does the standard mean for people?
• You will be cared for by skilled and knowledgeable staff. • Your care partners are recognised and supported. • You will be understood, listened to and treated with kindness and respect by staff. • You will be supported to raise concerns and told how to access an independent complaints process.
What does the standard mean for staff?
Staff: • are given opportunities and time to develop and maintain the knowledge and skills required for their role • are empowered and supported to do the right thing at the right time • understand the role of care partners and appropriate legislation relating to carers • are supported to speak out • work in a culture where they are encouraged to learn and improve • are supported with their own physical and mental wellbeing.
What does the standard mean for the organisation?
Organisations: • ensure staffing levels are adequate • ensure staff have access to appropriate training and continuous professional development • have systems and processes in place to identify care partners and provide the support and training they need • create a culture of learning and improvement • ensure policies and processes are in place to support staff wellbeing.

Examples of what meeting this standard might look like
• TURAS module uptake: care of older people. • TURAS module uptake: delirium and dementia. • Implementation of 'frailty at the front door' toolkits, training and change packages. • Carers' policy or strategy embedded into working practices. • Informal update of training and resources for care partners. • Carers assessments. • Frailty audits matched to staff requirement and safe staffing. • Commissioning data for training provision from a range of sources including third sector delivery. • Access to chaplains and spiritual care advisers.

Standard 5: Keeping active

Standard statement

Older people with frailty are supported to keep active to maintain and improve mobility, independence and function.

Rationale

Keeping physically active and mobile can reverse or prevent frailty and falls.[37] People with frailty have reported a sense of achievement, satisfaction and confidence when increasing their mobility through physical activity.[38] Social prescribing to community activities and social clubs, particularly outdoors, leads to reported higher quality of life.[39, 40] It may support people to maintain their physical activity as they age.

People who are enabled, supported and encouraged to maintain and improve their mobility experience a higher quality of life as they age.[41] People should be supported to engage in meaningful and purposeful physical activity and to do things that are important to them.[42-44] People should be enabled and supported to make informed choices about movement and activity.[45]

Deconditioning is the decline in physical function of the body. This happens as a result of physical inactivity, bedrest or an extremely sedentary lifestyle. It is caused by immobility, for example during or after a period of acute illness or injury, surgery or hospitalisation. Up to 65% of older patients experience decline in function during hospitalisation.[46] Sarcopenia is an age-related progressive loss of muscle mass, function and strength. People with sarcopenia are three times more likely to fall during a follow-up period of two years.[47] A comprehensive assessment followed by multidomain interventions should be undertaken to reduce falls in older adults living in a care home or staying in hospital.[48]

Criteria

5.1 People are provided with advice and information in a language and format that meets their needs about:

- how to improve or maintain mobility
- how to reduce deconditioning
- their likelihood of falling
- how to set and track physical activity goals that are important to them.

5.2 Organisations have a process for multidomain falls assessments[48] that includes discussion with the person and covers:

- mobility
- sensory function
- activities of daily living
- cognitive function
- autonomic function
- medical diagnoses
- medication and polypharmacy
- nutrition and hydration
- risk of falls caused by their environment.

5.3 Staff are trained and supported to:

- promote and encourage mobility and independence in all care settings
- reduce the likelihood of falls
- provide tailored education on falls prevention.

5.4 People with identified falls risk factors have a care plan to meet their needs that:

- is developed with the person
- is shared in an appropriate language and format
- includes a seven-step polypharmacy review.

5.5 Organisations ensure that processes, environments and services enable physical activity and movement.

5.6 People with frailty receive a home assessment from an appropriately skilled professional to optimise their independence and safety at home (including care homes).

5.7 People have access to advanced technology to:

- enable them to maintain mobility and independence
- detect when a fall has happened or allow the person to call for immediate help.

5.8 People at high risk of falls are involved in developing a multidisciplinary rehabilitation plan that includes:

- goals and outcomes
- a progressive exercise programme for a minimum of 12 weeks[48] which is community-based where appropriate
- rapid provision of equipment, for example equipment or adaptations to the person's home (or care home)
- clinically safe alternatives to hospital care
- support to maintain their skills and function in hospital while they wait for discharge.

5.9 Goal-focused and person-led rehabilitation and prehabilitation is carried out by a multidisciplinary team with relevant skills and expertise.

5.10 People with advanced frailty are supported to undertake physical activity based on their own values and priorities.

5.11 Care partners are provided with the right information and support to enable people with frailty to keep active, reduce falls and prevent deconditioning.

What does the standard mean for people?
• You will be encouraged and supported to keep active as you age. • You will be supported to focus on daily activities and movement that are important and useful for you. • You will have a care plan to keep you safe if you are likely to have a fall. • You will have access to technology that can either detect when a fall has happened or allow you to call for help following a fall. • If you have a fall, you will be able to access appropriate support and rehabilitation.

What does the standard mean for staff?
Staff: • work with people to understand their needs, priorities and goals • have the right knowledge and experience to promote keeping active and encourage independence • undertake an assessment of a person's risk of falling and act on it • work in partnership across different sectors to reduce the risk of falls • understand the important role of care partners in promoting and encouraging meaningful activity • are aware of and follow referral pathways for rehabilitation across the health and social care partnership.
What does the standard mean for the organisation?
Organisations: • demonstrate strong leadership to balance the safety of older people with the promotion of independence and physical activity • have processes and protocols in place to manage the risk of falls • have systems in place for assessing and providing appropriate technology and equipment • develop and review high quality, accurate information on safer mobility in a range of different languages and formats.
Examples of what meeting this standard might look like
• Data on length of stay in hospital, falls and readmission rates due to falls. • Use of activity charts. • Community prehabilitation and rehabilitation programmes. • Pathways that trigger a polypharmacy review to ensure medications are considered as a potential contributory factor in a fall. • Pathways in place to trigger a comprehensive review of potential reasons for falls.

Standard 6: Nutrition and hydration

Standard statement

Older people with frailty have their nutritional and hydration needs identified and met.

Rationale

Nutrition in older people has been identified by the World Health Organization as a key priority area for healthy ageing.[49] Poor quality of diet, including the lack of intake of key micronutrients, may lead to loss or reduction in muscle mass, decline in immune or cognitive function and unintentional weight loss.[50, 51] Excess calories may also be associated with poor quality of diet. Some chronic conditions can affect mobility or swallowing, which can impact a person's nutritional intake and their enjoyment of eating and drinking.

Malnutrition is common in older people with frailty. [52-54] Up to one third of people over 65 requiring hospital admission and 40% of care home residents are at risk of malnutrition.[55] Improving the early identification and treatment of malnutrition can have a positive effect on quality of life, recovery, rehabilitation, length of stay and readmission rates.[52, 54, 56]

Eating and drinking has important social and cultural components. A person's dignity and rights should be upheld when they need to be supported to eat and drink. When someone is dying, a gradual reduction in oral intake is natural. At this time, people and their care partners should be supported to focus on enjoying food and the social interaction associated with eating and drinking.

Criteria

6.1 Staff undertake a nutritional care assessment for people at risk of frailty that includes:

- relevant physical measurements
- food allergies or intolerances
- eating and drinking likes and dislikes
- cultural, ethnic or religious dietary requirements
- social and environmental mealtime requirements
- the need for help and support with eating and drinking.

6.2 People at risk of malnutrition are able to access:

- supplements for micronutrients including vitamin D
- fortified or high calorie foods.

6.3 People have access to an assessment by an appropriate healthcare professional for support with swallowing, including:

- speech and language assessment and advice
- alternative formulation, routes or dosing of medicines
- modifications to textures of food and drink
- supplements that do not require swallowing, if assessed as appropriate
- posture and physical requirements.

6.4 Organisations have agreed referral pathways for support with eating and drinking.

6.5 People are supported to eat with others, including their family or communities, if they wish.

6.6 People are given the time, equipment and assistance to eat and drink in line with their informed choices.

6.7 Staff are adequately trained to identify and meet people's individual nutritional needs.

6.8 Care partners are supported to understand people's changing nutritional and hydration needs and choices, particularly when the person they care for is very frail or dying.

6.9 Organisations signpost to community and social care organisations that may be able to assist people with their food, fluid and nutritional care, for example community food initiatives, food co-ops, shopping services and meal services.

6.10 Staff undertake ongoing reviews of clinically-assisted nutrition and hydration, taking into account a person's choices.

6.11 A person's religious and philosophical beliefs in relation to food and diet are adhered to in all settings.

What does the standard mean for people?
• You will be supported with enough time to eat and drink and have access to equipment that you may need to help you with this. • Any medical interventions to support your nutrition will be the least invasive or restrictive and reviewed regularly. • Your choices and requirements about eating and drinking will be respected. • You will be supported to understand how what you eat and drink impacts on your physical health and wellbeing.
What does the standard mean for staff?
Staff: • are able to provide basic dietary advice for an older person living with frailty • recognise and respond appropriately to signs of dehydration • respect and support decisions related to eating and drinking • support people to make informed decisions about clinically-assisted nutrition and hydration.
What does the standard mean for the organisation?
Organisations: • have processes to identify and address people's nutrition and hydration • provide equipment and access to specialist input to support people to eat and drink • design systems and processes to support choice • enable people to eat and drink with others.
Examples of what meeting this standard might look like
• Protocols for nutrition and hydration screening and assessments. • Reduced prevalence of malnutrition. • Evidence of pathways for equitable access to specialist nutrition and hydration support. • Alternative menus to allow choices about food and drink. • Protected mealtimes with support from care partners and family. • Registries or databases of community groups and organisations.

Standard 7: Medicines management

Standard statement

Older people with frailty are supported to discuss and understand the benefits, risks and alternatives of medicines and their medicines are regularly reviewed.

Rationale

People living with frailty often have multiple long-term health conditions that require medication. Older people are more likely to experience side effects and medicines-related harm. People who are taking five or more medications are at a higher risk of falling.[57]

People should be fully informed about medications, their purpose and their side effects. They and their care partners should be supported with medications at home, with access to medication aids when required. The principles of Realistic Medicine should be considered when prescribing for older people with frailty. The use of BRAN (benefits, risks, alternatives and what happens if you do nothing) questions can support people to be involved in decision making, reducing harm and personalising their treatment.[58] For example, as psychotropic medicines in frail older people are associated with several adverse outcomes, their use should be avoided if possible.

Reviewing and stopping unnecessary medication can improve a person's quality of life and reduce anxiety, pain and low moods.[59] Reviews should take into account a person's whole circumstances, including sensory impairments, comorbidities and their choices and preferences.[60] Where possible, prescribers should consider non-medical or non-pharmacological methods of treating side effects. Sustainable, nature-based 'blue green' prescribing can support people to access activities and outdoor space.[61] This may improve mental health and chronic pain, reduce pollution and prevent antimicrobial resistance.[39]

Reducing unwarranted prescribing of antibiotics is important to help reduce antimicrobial resistance. In general, reducing unwarranted prescribing also reduces any harmful health effects of climate change.

As people become increasingly frail, their life expectancy falls and the priorities of treatment can often change. Instead of prescribing to reduce the risk of potential 'major events' and for general life prolongation, the focus can move to symptom control and reducing harm. When a person is dying it is often appropriate to reduce or stop regular medication and to consider 'just in case medication' that can be accessed quickly if and when required.

Criteria

7.1 People taking five or more medicines, or any high-risk medicine for frail older people, such as anticholinergics, antipsychotic, receive an annual person-centred medication review led by an appropriate healthcare professional.

7.2 When prescribing medications, staff have a discussion with the person about:

- the benefits
- the risk of medication causing harm
- alternatives to prescribing
- the likely outcome of not prescribing the medicine.

7.3 Staff contribute to and can access a single pharmaceutical care plan for each person with frailty.

7.4 People receive medicines reconciliation:

- within 24 hours of admission to an acute care setting
- when they are discharged from hospital or when they move between health or care settings.

7.5 Structured medication reviews using a seven-step approach are considered when there is a change in a person's health, choice or circumstances or as part of preparation for planned surgery.

7.6 People who have been discharged from hospital receive an appropriate supply of medication.

7.7 People are supported to:

- discuss their medication, including experience of side effects and any concerns they have, with an appropriately trained professional
- manage and self-administer their medication
- set targets for pain and chronic disease management in partnership with healthcare professionals
- understand the purpose of their medication
- encouraged to take their medication within the principles of informed choice.

7.8 Organisations demonstrate safe and rights-based procedures for appropriate administration of medications where:

- a person does not have capacity
- covert medication is being considered.

7.9 Changes to a person's medication are communicated across the multidisciplinary team in consultation with the person.

7.10 Medicines for pain and symptom management are prescribed and given in line with current guidelines.

7.11 People and their care partners are involved in decisions about the supply and use of 'just in case' medicines if they are dying.

7.12 People who are dying have medicines stopped where appropriate.

7.13 Care partners:

- receive information about medication, including possible side effects
- receive information and guidance to support the person to take their medication
- are informed about any changes to medication and the reason for the change.

What does the standard mean for people?
• You will have the opportunity to discuss the risks and benefits of any medication before it is prescribed. • You will be supported to understand what your medication is for and what side effects you may experience. • You will be able to access the correct medication in the correct form when you need it. • You will be supported to take your medication. • If you are on many different medications, these will be reviewed annually to check they are still right for you. • Your care partner(s) will have the information and guidance they need to support you to discuss and take your medication.
What does the standard mean for staff?
Staff: • prescribe medication in line with best practice and current guidelines • ensure people are able to make informed choices about their medicines and are supported to take them • have an awareness that older people with frailty are more likely to experience side effects from medication • conduct regular medication reviews using a structured approach.

What does the standard mean for the organisation?
Organisations: • demonstrate a good understanding of medication reconciliation, polypharmacy reviews and a Realistic Medicine approach to prescribing • have systems and processes in place for seven-step polypharmacy reviews • provide training and support to staff undertaking medication reviews.
Examples of what meeting this standard might look like
• Documentation in clinical notes that a polypharmacy review has taken place. • Covert medications policies. • Just in Case medication policy. • Health and Social Care Medication Policy. • Medicines Reconciliation Policy. • Electronic pharmacy records accessed across care settings. • Use of electronic systems and other systems and processes, for example Hospital Electronic Prescribing Medication and Administration, Medication Administration Recording and Requesting. • Electronic Discharge Document shared with appropriate people and services.

Standard 8: Living and dying well

Standard statement

People's wellbeing and enjoyment of older age is maximised and they are enabled to live well until the end of their life.

Rationale

Frailty can challenge a person's sense of self. It can affect how they are perceived and treated by others, including health and care professionals. Feeling valued, respected and able to take part in meaningful activities is important for quality of life and can prevent or delay significant health or social care needs.[62] People's life and their choices about how they live it should be respected and enabled as they grow older.

People's wellbeing and how they live their lives is impacted by range of things. As people age, they may need support to adapt to changes in their life and health. Declining health and loss of abilities may affect a person's wellbeing and their engagement with the world and with others. [20] Pain, illness, falls and loss of memory may challenge a person's sense of identity, meaning and purpose.

Social connection is integral to most people's positive mental and spiritual wellbeing. Social isolation and loneliness is associated with physical health conditions such as cardiovascular disease and stroke.[63] Social connection, including community connection and activity, has a positive impact on cognition and may delay the onset of dementia.[64] Social prescribing can support people to access community groups.

Frailty may lead to incontinence and bladder and bowel issues. These can significantly impact quality of life, dignity and daily activity. Sensory impairment, particularly vision and hearing, is common in older people. If not corrected, it can have a negative impact on their ability to engage with others and the world around them. Services should promote multidimensional wellbeing and enable daily activities that matters to people.

Older people with frailty may have thoughts and questions about their future.[65] People living with frailty should have opportunities to talk about spiritual or cultural matters, including death and dying and the meaning of life for them. Staff should be receptive to these questions. They should support people to access spiritual or specialist palliative care.

Staff should be trained and supported to have open conversations with people about what matters to them as their health declines. Future care planning should be offered if a person's health is declining or likely to decline. People who are dying should have pain and other symptoms well managed to keep them comfortable. They should be treated with dignity and their spiritual or cultural needs, as well as those of their care partners, should be respected and addressed.

Criteria

8.1 People are supported to access fundamental aspects of personal care to promote wellbeing and daily function, including:

- their likelihood of developing pressure ulcers
- personal hygiene
- dignified management of continence issues
- oral care
- hearing and sight loss.

8.2 Organisations support people's wider activities of daily living such as leisure, activities, interests and vocation.

8.3 People are supported to access activities and programmes to support their social, spiritual and mental wellbeing.

8.4 Organisations support people to access and maintain community connection and reduce social isolation through referral pathways and informal partnerships.

8.5 People have access to support services and equipment to support independence and manage activities at home.

8.6 People can access non-pharmaceutical advice and management for pain, breathlessness, fatigue or poor appetite.

8.7 Organisations have processes to identify and respond to distress, confusion, grief and anxiety.

8.8 People and their care partners are supported to adjust to changes in their life, including loss and bereavement.

8.9 People are involved in decisions about activities that may cause harm to them and enabled to make choices in line with their values and enjoyment.

8.10 People are enabled and supported to have:

- honest, compassionate conversations about living well with deteriorating health
- early discussions about palliative care and the support available for people and their care partners
- conversations about what happens when someone is dying
- information about care and treatment options they have when they are dying.

8.11 People who are dying receive:

- involvement in decisions, including about where to die
- a holistic assessment of their needs
- rapid and responsive advice, information and support at any time
- dignity and compassion
- personalised care
- necessary equipment and medicines.

What does the standard mean for people?
• Your life and how you want to live it will be respected. • You will receive the support and care you need for daily activities, leisure and things that are important to you. • You will be supported to maintain your social networks, activities and contact with your local community if you want to. • You will be supported by staff, care partners and services to live as well as possible for as long as possible. • If your health declines, you will be supported in ways that matter to you. • If you are dying, you will be cared for in ways that mean you are comfortable and safe, with involvement of the people that matter to you.
What does the standard mean for staff?
Staff: • support people to live their lives as well as possible in line with their values • are able to talk with people about healthy living and wellbeing as well as declining health, loss, dying and death • apply best practice relating to capacity, informed decision making and rights of individuals to make decisions that may involve balancing risks and benefits • help people to access services and voluntary and community initiatives which would promote their wellbeing • recognise and respond to cultural and spiritual needs of people living with frailty throughout their illness, from diagnosis to death and bereavement • recognise when a person is dying and provide high quality care around death in line with best practice.

What does the standard mean for the organisation?
Organisations: • plan and design services to promote multidimensional wellbeing and enable daily activities that matter to people • actively promote effective relationships between statutory and voluntary organisations, communities, public bodies and other agencies that facilitate wellbeing for older people living with frailty • have processes and procedures in place to support dignity, respect and person-centred care when a person is dying • ensure equity of access to specialist palliative care across settings where people with frailty are likely to be, including care homes, community hospitals and acute hospitals.
Examples of what meeting this standard might look like
• Use of regular prompts about how someone feels about their wellbeing. • Documenting referral onto other agencies to support wellbeing. • Commissioning data for community wellbeing and healthcare services. • Evidence of social prescribing to community groups, activities and social clubs.

Standard 9: Care in hospital

Standard statement

Frail older people in hospital receive equitable, compassionate and safe care that promotes wellbeing and reduces the risk of harm.

Rationale

Frail older people make up a large proportion of hospital patients. All hospital-based staff should understand the needs of older people with frailty. This includes during acute assessments in emergency departments and assessment wards, inpatient wards, outpatient clinics and when planning for elective surgery. Attending hospital may be the opportunity to identify and recognise frailty, or to take measures that reduce the progression of frailty. In Scotland, a CGA in acute admission to care of older people services is directly linked to length of hospital stay.[66]

Inpatient stays may lead to a decrease in physical activity, to incontinence and to communication issues that result from unrecognised sight or hearing loss. Lights or noise in hospital wards may increase distress and delirium in people with frailty.[67] People with frailty are at increased risk of healthcare associated infections. Identifying people with frailty in acute care should not prevent full, timely access to high dependency units, intensive care units, surgery and other appropriate treatments.

Upon discharge from hospital, it is essential that the individual and those that will be continuing to support them have sufficient information about what happened during their hospital stay. This should include any changes to medication or follow-up that the individual requires. Under the Carers (Scotland) Act 2016, carers should be involved in discussions about discharge.[22]

One in three acute hospital beds in Scotland is being used by people who are within their last year of life. These people are predominantly older people with frailty. Delays in recognising and acknowledging dying in hospital often lead to treatments that may be unnecessary or exacerbate suffering. Support and care, including communication with care partners, is essential for high quality care around the time of death.

Criteria

9.1 NHS boards have appropriate risk assessed frailty pathways for caring for people in all hospital areas, including emergency care, surgery and mental health.

9.2 People in hospital are screened for frailty and have prompt access to a multidisciplinary frailty team, if appropriate, for support, advice or transfer of care.

9.3 Wards caring for people who may be at risk of frailty:

- have appropriate lighting and noise levels for the time of day
- provide a private space for older frail people who are dying
- are designed to promote safe mobility and routine activity
- provide information that aids communication, for example large signage
- support people's care partners, friends and families to visit
- promote healthy sleep and encourage a normal sleep pattern
- promote wellbeing and demonstrate a human rights-based approach to their stay in hospital.

9.4 Staff in hospitals promote and enable:

- dignity and privacy
- independence
- engagement in activity
- continence
- skin care
- oral health.

9.5 People with frailty are not moved between wards or into areas not dedicated to patient care unless it is demonstrably in their best interests.

9.6 People with frailty can access:

- life-saving treatment, including access to high dependency or intensive care, where clinically appropriate
- specialist palliative care
- rapid discharge to be able to die at home where this is the person's choice and is clinically appropriate.

9.7 The care and support needs of people who are delayed from hospital discharge are reviewed weekly.

9.8 Services act in the best interests of people who experience being delayed in hospital including:

- reducing the number of moves between wards and services
- ensuring equitable access to high quality healthcare
- integrated working to support discharge planning.

9.9 Proactive and early discharge planning and future care planning begins on admission and continues as a person's choice and circumstances change.

9.10 People in hospital have a planned discharge date set and are part of discussions with members of the multidisciplinary team to work towards achieving this.

What does the standard mean for people in hospital?
• You will be cared for in a clinical environment that meets your needs. • Your care partner is able to visit and keep supporting you, along with other friends and family. • You will be safe and able to maintain your independence. • You will have access to specialist support. • When you are ready to leave hospital, you will be involved in decisions about where you are going and how you will get there. • If there are changes to plans, you are kept informed.
What does the standard mean for staff?
Staff: • recognise and respond to signs of frailty in people in hospital • undertake assessments in line with their roles and responsibilities • ensure wards are designed to be dementia-friendly, psychologically-informed, safe and empowering • support and empower people to maintain physical activity and continence, where possible • have sufficient and timely information at point of discharge • share information to enable continuation of care.
What does the standard mean for the organisation?
Organisations: • have processes in place to identify people with frailty in all relevant hospital departments • ensure CGAs are undertaken • ensure ward environments meet the specific needs of people with frailty • develop plans and policies to reduce transfer between wards or care settings • meet the needs and rights of people awaiting discharge.

Examples of what meeting this standard might look like
• Data related to number of people in hospital waiting for discharge. • Data related to reasons for delayed discharge. • Data related to where people stay and how long they stay for. • Readmission rates.

Standard 10: Delirium, dementia and cognition

Standard statement

Older people experiencing a change in their cognition or mental state are identified, understood and supported.

Rationale

Cognition is the act of thinking, perceiving and understanding. Delirium is an altered state of consciousness characterised by episodes of confusion.[68] It may affect memory, thinking and ability to perform activities of daily living.

People in hospital or long-term care are at higher risk of delirium and the serious negative consequences associated with it.[69] Delirium carries with it an increased risk of falls, a longer hospital stay and mortality. Staff should identify and address causes of delirium such as a person's environment, medications or health factors (for example, dehydration.)[68, 69]

Older people are more at risk of dementia. Frailty is also independently associated with increased risk of dementia. Frail older people living with dementia are at higher risk of delirium, infection, malnutrition, dehydration, constipation and falls when they are admitted to hospital.[64]

All healthcare practitioners should assess a person's capacity to consent to their treatments as part of routine care. When a cognitive impairment is observed, staff should undertake a formal assessment. Staff should understand the relevant legislation at a level appropriate to their practice. This includes understanding the legal requirement to discuss with legal proxies and those close to the person when they do not have full capacity for decision making.[70]

Criteria

10.1 Identification and further assessment of changes in cognition, delirium and dementia is based on:

- brief cognitive tests
- neuropsychological assessment as appropriate[71]
- the person's circumstances and experience
- information from care partners and staff members.

10.2 Information about a person's cognition, including previous episodes of delirium or a diagnosis of dementia, is shared between services and staff.

10.3 Screening and personalised risk reduction strategies are provided to those at risk of delirium.

10.4 Staff are aware of the potential impact of medicines and medicine withdrawals on cognitive function and apply this knowledge during medication reviews.

10.5 People with a cognitive impairment are provided with personalised management plans and communication strategies.

10.6 People with a cognitive impairment feel safe, involved and well cared for in their care environment.

10.7 Staff assess capacity to consent throughout all care and specifically when a cognitive diagnosis is made.

10.8 Staff caring for people with a cognitive impairment:

- use appropriate legislation to safeguard them
- involve next of kin or legal proxies in decisions.

10.9 The care partners of people with dementia, delirium or cognitive impairment are provided with support and information.

What does the standard mean for people?
• Any concerns about your memory, thinking or understanding will be addressed. • Your care, including the medicines you take and the place you are cared for, will take account of any delirium, dementia or cognitive problems you have. • Staff will talk to you about your care in a way that you can understand. • Staff will carefully assess your ability to make decisions. They will involve your legal proxies or next of kin in decisions about your care if you are unable to make decisions for yourself.
What does the standard mean for staff?
Staff: • understand appropriate responses and management options for people living with cognitive impairment • know which services are available to help support people with cognitive impairment and how to access support at the right time • share information about a person's cognitive ability where appropriate • understand the importance of capacity and consent, how to assess it and what to do if a person cannot consent • can help support people who are experiencing stress or distress.

What does the standard mean for the organisation?
Organisations: • have clear processes and procedures to identify, assess and manage cognitive impairments • provide training to staff on how to prevent, recognise and respond to delirium • provide relevant information to people and their care partners in a format and language that is understandable and accessible • provide care in an environment that minimises the risk of delirium.
Examples of what meeting this standard might look like
• Monitored outcomes of people admitted into hospital with cognitive change, dementia and delirium. • Waiting time for specialist psychiatry input. • Education materials in place, with appropriate counselling or support services (including spiritual needs). • Use of screening tools and assessment for diagnosis of cognitive change.

Standard 11: Mental health

Standard statement

Older people with frailty have their mental health assessed and supported.

Rationale

Mental health is a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well.[3] It is about life satisfaction, optimism, self-esteem, feeling in control, having a purpose and a sense of belonging and support.[72]

Older people with frailty may experience depression, loneliness and low levels of satisfaction and wellbeing.[73] Depression can exacerbate isolation, disempowerment and cognitive decline.[3] Taking part in meaningful activities, maintaining and developing personal identity, and getting the right help for any health conditions and sensory impairments are key to improving mental wellbeing.

Older people with frailty are likely to display anxiety. Anxiety is more likely to be undiagnosed or normalised as an appropriate response to falls and is linked to adverse health outcomes.[74]

Older people may have mental health conditions that they have lived with through their lifetime, or they may develop them later in life. People taking antipsychotic medications may experience cardiometabolic side-effects that cause cognitive impairment. This should be taken into account when undertaking mental health and wellbeing assessments.

Criteria

11.1 People's mood and psychological status are assessed and recognised during:

- holistic assessments, including CGA
- ongoing care planning
- change in care setting
- communication and shared decision making.

11.2 Organisations regularly and proactively screen for mental health conditions in people with frailty.

11.3 Staff identify older people who are at high risk of frailty due to mental health conditions, medication side-effects, substance use or socioeconomic circumstances.

11.4 Older people with frailty and mental health conditions have access to appropriate evidence-based management and treatment, including medication and talking therapies.

11.5 Inpatient mental health care, if required, is:

- rights-based
- safe
- therapeutic
- adapted to meet a person's needs and level of frailty.

11.6 Organisations identify barriers to people accessing care related to their mental health and proactively seek to overcome those barriers.

11.7 People with long-term or enduring mental health conditions have equitable access to physical health interventions to manage frailty.

11.8 Prescriptions of psychoactive medications, including antidepressants and sedatives, are considered and reviewed regularly.

What does the standard mean for people?
• Your mood, mental health and psychological state will be recognised, assessed and cared for. • Staff will take account of any mental health or psychological issues you have when they are caring for you. • You will be referred for specialised mental health care if you need it.
What does the standard mean for staff?
Staff: • routinely assess the mental health of older people at risk of frailty • understand appropriate responses and treatment options for people with mental health conditions • understand the importance of mental wellbeing and the factors that contribute to good mental health • work with specialist mental health team to support older people with frailty.

What does the standard mean for the organisation?
Organisations: • have systems and processes in place to identify and respond to the mental health needs of older people with frailty • have referral pathways to specialist input where required.
Examples of what meeting this standard might look like
• Referral pathways to mental health treatment. • Implementation of mental health standards. • Consistent screening for depression, mental health and wellbeing in people with or at risk of frailty.

Appendix 1: Development of the ageing and frailty standards

The standards have been informed by current evidence, best practice recommendations and have been developed by group consensus.

Evidence base

At the start of the standards development process, the project team carried out a literature search to identify qualitative and quantitative studies that addressed patient issues of relevance to the delivery of services. Databases searched include Medline, Embase, Cinahl and PsycINFO.

We undertook a systematic review of the literature using an explicit search strategy devised by an Evidence and Information Scientist from the Research and Information Service. We searched databases including Medline, Embase, Cinahl, PsycINFO and the Cochrane Library. The year range covered was 2000-2022. Members of the Standards Development Group supplemented the main searches with other material that they identified.

A Health Services Researcher adopted a systematic approach to provide an evidence base for these standards. Eligibility criteria was devised to support the literature sift. Articles were included if they were:

- guidelines
- systematic reviews
- empirical evidence providing practice guidance
- English language only
- relevant to Scotland
- focused on a population including older adults with frailty.

Articles were excluded if they did not provide substantive reference to frailty. The project team summarised the results and presented them to the Standards Development Group.

Standards development

Each standard is underpinned with the views and expectations of health care staff, third sector representatives, people accessing the service and the public. Information has been gathered from a number of sources and activities, including Standards Development Group meetings and a consultation survey on the draft scope.

Consultation feedback and finalisation of standards

Following consultation, the Standards Development Group will reconvene to review all comments received and make final decisions and changes. More information can be found in the consultation feedback report which will be available on the HIS website.

Quality assurance

All Standards Development Group members were responsible for advising on the professional aspects of the standards. Clinical members of the Standards Development Group advised on clinical aspects of the work. The co-chairs had lead responsibility for formal clinical assurance and sign off on the technical and professional validity and acceptability of any reports or recommendations from the group.

All Standards Development Group members made a declaration of interest at the beginning of the project. They also reviewed and agreed to the Standards Development Group's terms of reference. More details are available on request from his.standardsandindicators@nhs.scot.

The standards were developed within the Operating Framework for Healthcare Improvement Scotland and the Scottish Government (2022), which highlights the principles of independence, openness, transparency and accountability.

For more information about HIS's role, direction and priorities, please visit: www.healthcareimprovementscotland.org/

Appendix 2: Membership of the Standards Development Group

Name	Position	Organisation
Paul Baughan	**Co-Chair** GP/Professional Advisor for Ageing and Health	NHS Forth Valley/Chief Medical Officer Directorate, Scottish Government
Phyo Kyaw Myint	**Co-Chair** Professor of Medicine of Old Age and Honorary Consultant Geriatrician	University of Aberdeen/NHS Grampian
James Battye	Senior Improvement Advisor	Healthcare Improvement Scotland
Leanne Black	Lead Clinical Pharmacist Frailty	NHS Greater Glasgow and Clyde
Anne Blackburn	Retired district nurse/ midwife	Scottish Older People's Assembly (SOPA)
Kirsty Boyd	National Clinical Lead for Palliative Care	Scottish Government
Janice Cameron	Joint National Lead	Scottish Care
Mark Delicata	Consultant Physician– Medicine for the Elderly	NHS Fife
Joanna Earle	Inspector	Healthcare Improvement Scotland
Ros Fraser	Speech and Language Therapist	NHS Lothian
Scott Hamilton	Improvement Advisor	Healthcare Improvement Scotland
Mhairi Hastings	Associate Director of Nursing	Healthcare Improvement Scotland
Chris Hay	Geriatric Registrar	NHS Greater Glasgow and Clyde

Name	Position	Organisation
Mark Hazelwood	Chief Executive	Scottish Partnership for Palliative Care
Vicky Hough	Senior Clinical Pharmacist	NHS Forth Valley
Lynsey Kemlo	Senior Improvement Adviser	Care Inspectorate
Laura Kerr	Adults Policy and Practice Lead	Social Work Scotland
Kyrsta Macdonald-Scott	Advanced Practice Physiotherapist	NHS Lothian
Phil Mackie	Consultant in Public Health	NHS Grampian
Nicola McArdle	Senior Improvement Adviser	Care Inspectorate
Lucy McCracken	Consultant Geriatrician	NHS Greater Glasgow and Clyde
Louise McKay	Nurse Consultant, Older Adults	NHS Forth Valley
Hazel Miller	Consultant Geriatrician	NHS Greater Glasgow and Clyde
Jane Mimnaugh	Alzheimer Scotland Nurse Consultant	NHS Lanarkshire
Lara Mitchell	Consultant Medicine for the Elderly National Clinical Lead Frailty	NHS Greater Glasgow and Clyde
Susan Moug	Consultant General and Colorectal Surgeon	NHS Greater Glasgow and Clyde
Connie Murray	Improvement Advisor	Healthcare Improvement Scotland
Shona Omand-Smith	Commissioning Lead	Aberdeen City Health and Social Care Partnership
David Paterson	Chair	Scottish Older People's Assembly (SOPA)
Joy Reid	Nurse Consultant Older People and Frailty	NHS Fife

Name	Position	Organisation
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Rowan Wallace	Consultant Older People's MedicineBritish Geriatrics Society Scotland	NHS Ayrshire and Arran
Eilaine White	Clinical Academic Nurse Consultant for older people	NHS Tayside/University of Dundee

Appendix 3: Membership of the Standards Steering Group

Name	Position	Organisation
Paul Baughan	**Development Group Co-Chair** GP/Professional Advisor for Ageing and Health	NHS Forth Valley/Chief Medical Officer Directorate, Scottish Government
Phyo Kyaw Myint	**Development Group Co-Chair** Professor of Medicine of Old Age and Honorary Consultant Geriatrician	University of Aberdeen/NHS Grampian
Harriette Campbell	Vice-chair	Scottish Older People's Assembly (SOPA)
Jacqueline Dennis	Senior Improvement Adviser	Care Inspectorate
Mark Evans	National Spiritual Care Strategic Advisor Operational Lead	Scottish Government
Jennifer MacDonald	Inspector - Quality of Care	Healthcare Improvement Scotland
Lucy McCracken	Consultant Geriatrician	NHS Greater Glasgow and Clyde
Marie McKerry	Chief Nurse	Care Inspectorate
Winifred McLure	Senior Inspector – Quality Assurance Directorate	Healthcare Improvement Scotland
Lara Mitchell	Consultant Medicine for the Elderly National Clinical Lead Frailty	NHS Greater Glasgow and Clyde
David Paterson	Chair	Scottish Older People's Assembly (SOPA)

Name	Position	Organisation
Marie Paterson	Chief Inspector for Adult Services	Care Inspectorate
Belinda Robertson	Associate Director of Improvement	Healthcare Improvement Scotland
Fiona Wardell	Standards and Indicators Lead	Healthcare Improvement Scotland

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