Department of Health

# National Learning Network Event
## Thursday 22nd September, 2005

# Older People

national service framework

## Standard 4 – General Hospital Care 2004/06 Project

# Foreword

Pioneers are people that go to places, or do things, that few have visited or done before. In this sense the people who have organised and delivered the programme of work, summarised in this booklet, are very definitely pioneers.

The work has been difficult and highly original. It has very clearly necessitated moving out of the "comfort zone" of usual daily life and risking exposure to degrees of hostility and testiness that are commonly engendered when we attempt changes to usual custom and practice in the health service. Much skill, perseverance and commitment to the work has been required. For this, we are hugely grateful.

In some ways, what we have attempted may seem simple. At least it can be very simply and succinctly summarised; that the contemporary acute hospital (there are teaching one's too) should be regarded as an older person's health care facility. At one level, it is easy to argue the case for this. The usual statistics can be rolled out; older people occupy over two thirds of hospitals beds; have longer lengths of stay; comprise the majority of trolley waits in casualty; the majority of delayed discharges; etc.

However, it is one thing for people to be familiar with facts and to have knowledge in their heads and another for them to apply these in a meaningful way. Real change can only occur if this knowledge is understood, not superficially, but profoundly. This deeper level of understanding, one in which the implications and critical change issues become recognised, is a major challenge to achievement in the busy world of the NHS. Prompting this higher level of understanding about the modern hospital as a service focused on the needs of its core user group, older people, has been at the heart of the work described here. The hope was that a few people, well supported within their organisation, could effect major changes in the care experience of older people in general hospitals.

We believe that others who read this booklet will be surprised at what has been achieved in a brief period by a few people working in large and complex organisations. We hope they might be encouraged to embark on something similar.

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# Introduction

The NSF for Older People was published in March 2001. It set new national standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital. The NSF has eight standards:

1. Rooting out age discrimination
2. Person-centred care
3. Intermediate care
4. **General hospital care**
5. Stroke
6. Falls
7. Mental health in older people
8. The promotion of health and active life in older age

In September 2003 additional revenue funding was announced of £5.6m over two years to support implementation of Standard 4 (General Hospital Care) of the NSF for Older People. PCTs, working with acute trusts, were invited to bid for funds to run projects to help implementation.

**Standard Four - General hospital care**

*Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.*

The projects were not to be a single initiative approach to improving services for older people, but something that would help bring about a fundamental refocusing. The project criteria were that they should be designed to:

- Help with the implementation of Standard 4 of the NSF for Older People.
- Achieve a better experience for older people receiving hospital care.
- Demonstrate how a focus on older people can help with access and capacity targets (in order to demonstrate that getting services right for older people can help get services right generally in hospitals).

Forty projects received central funding. The majority of the successful bids involved some form of training or education for staff across the whole of the acute trust, to ensure that they are skilled to assess and meet the needs of older people. By investing in training/education programmes, the plan is to change the whole culture of the hospital.

A Learning Network was established to support the project leads. Central support has been provided to disseminate information between the projects and four events have been held in 2004/2005 where project leads have had the opportunity to meet and share their experiences.

This booklet, produced for the final Learning Network event held in London on September 22nd 2005, provides information about all the projects, their progress and achievement to date. Contact details are given for each project and further copies are available in electronic format from jo@innove.info.

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# A Mental Health Assessment Service for Older People

Co-morbidity in the general hospital is common and likely to lead to a complex discharge. The majority of delayed discharges from hospital are older people with mental heath needs, especially dementia[1]. It is recommended that discharge from hospital is not an isolated event but a process that starts from the point of admission. This emphasises the importance of developing services to address the mental health needs of older people in the Accident and Emergency Department (AED). Prior to this project, the ***Aintree Hospitals NHS Trust*** provided no specialist mental health service for older people in AED, with the majority of patients who present with cognitive impairment being admitted for further medical investigations and mental health, functional and social assessments.

**Aims**

- To improve general hospital care for older people from the point of attendance at AED, with a view to providing a holistic assessment, preventing hospital admission and facilitating a timely discharge by improving links with community services.
- To generate exploratory evidence to identify the existing assessment processes and care pathways, patient profiles and specific areas requiring development.

**Project Approach**

A Mental Health Nurse was seconded to AED and the Medical Assessment Unit (MAU) to provide a rapid assessment service for older people presenting with mental health needs. The service was proactive in identifying appropriate referrals by being involved in the daily ward rounds and handovers, as well as screening the daily AED attendees. The service also responded immediately to offer staff advice and provide ongoing informal education.

**Achievements**

- Hospital admissions have been prevented and discharge expedited by direct referrals from AED and MAU to community mental health services for immediate follow-up or further assessment at home.
- Raised awareness of the rehabilitation needs of older people with mental health problems, which improved access to intermediate care from AED and MAU.
- Improved care pathways from AED and MAU to link in with the existing inpatient mental health liaison service and community services.

**Findings**

Initial exploratory evidence indicates:

- Poor use of the existing cognitive assessment tool and often a lack of a corroborative patient history.
- A need for improved access and links to mental health records and services to aid the triage/assessment process. Over half the patients assessed during the three months were previously known to mental health services; however this was not always apparent to the acute trust staff as both trusts use a different electronic database.
- A formal audit in the preliminary phase of the project was difficult, as cognitive impairment was rarely recorded as the primary problem.
- AED and MAU staff were receptive to the service and acknowledged the need for further education and service improvement regarding the screening and discharge of patients with cognitive impairment.

**Future Goals**

- To develop and implement care pathways in order to streamline the care of older people with mental health needs and improve access to both hospital and community mental health specialist services and intermediate care.
- To introduce assessment tools (CAM, MMSE) to aid the triage and assessment process and equip general hospital staff to identify and manage mental health problems from the AED and MAU.
- To develop formal education packages to support the use of assessment tools.
- To audit the use of cognitive assessment tools.

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[1] Department of Health (2003) Discharge from hospital: pathway, process and practice.

# *Wheels in Action - Turning for Older People*

The project is based within a large East London teaching hospital, ***Barts and The London NHS Trust***. Statistical analysis recognises that two thirds of our hospital beds are occupied by patients over the age of 65. Previous project work was located within the older people's speciality areas and this project offered an opportunity to transfer some of that learning and deliver further improvements in care and equity of access to services for older people throughout the trust.

**Project Approach**

The aims of the project are to improve the quality of care for older people in non older people's speciality areas, with a particular focus on Standard Nursing and Midwifery Advisory Committee (SNMAC) standards and indicators for best practice. The project is identifying the older person's pathway through the secondary and primary interfaces in parallel with current trust objectives. The previous NSF Steering Group has been redesigned to recognise the required involvement and accountability from all directorates in line with the trust governance structure. Focusing on redesigning has enabled us to focus our attention on direct projects, making the work more manageable and deliverable.

**Skills and Knowledge**

A skills gap analysis was performed to consider the aspects of care contained within SNMAC and Standard 4 in relation to training and learning already available to trust staff. A generic two day course has been developed to fill the identified gaps. The course is open to both clinical and non-clinical staff. Inclusion of older persons' needs and perspectives is now part of the trust's generic induction and re-certification programme.

**Single Assessment Process (SAP)**

A paper documentation process is in place post pilots. Communication of findings is established and shared within the acute trust, the PCT and Social Services. Increased achievements with predicted discharge dates and lengths of stay are reduced in some specialist areas.

**Public/patient Involvement**

This has led to the redesign of patient information throughout the trust including a discharge checklist and medication information. The Patients Accelerating Change project was set up to encourage older person's involvement and these members are now key user representatives on various trust committees. Two areas now have ward-based patient forums in place.

**Falls**

Standardised risk assessment tools and patient information are being piloted in the acute trust in conjunction with the PCT. Joint activity has also included a joint National Falls Awareness Day in July 2005.

**Privacy and Dignity**

Observations of practice identified the need to address and profile older person's privacy and dignity needs. Standards for ward rounds and protected meal times are now in place. Representation now exists on the trust's Essence of Care Practice Development Strategy as the resource lead for the Privacy and Dignity Benchmark.

**Strategic Outcomes and Consequences of the Project**

There is now a formal structure for the delivery and reporting of this work with a significant increased awareness of Older People's issues trustwide from ward to board. Older People's objectives are now integrated into the trust objectives and work streams.

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## *OPAL – Older People Always Learning*

The ***Bradford Teaching Hospitals Foundation Trust*** project started in June 2004 and is led by a Lead Nurse for Older People and supported by a management team in medicine, medical specialities and older person's care.

**Aims**

- To improve the care of older people across the organisation and achieve an increased understanding of their needs across all areas.
- To establish an awareness and understanding that all staff who work within adult services are caring for older people.
- To establish working relationships with partners in primary care and patient user groups.

**Project Approach**

- To change staff attitudes towards the care of older people and people with complex needs through education.
- To provide a variety of teaching approaches to integrate older people's needs within all training delivered in-house e.g. consent, venepuncture and cannulation.

**Achievements**

- Regular attendance of the Lead Nurse at older people's focus groups (PPI) means older people's issues are now integral to all education delivered within the trust based training and education department.
- A rolling programme of dementia care training has now been established.
- Older people's needs in acute care education are now delivered at university for pre and post registration students.
- Guidelines to assist with the assessment of older people have been developed and implemented across the trust.
- A general hospital care induction programme has now been established for all new D grade nurses to the trust.
- A competency based induction programme has been developed for the elderly and medical unit (to be extended trustwide following the pilot).
- A "Spot light on elderly care" column is now included in the trust magazine.
- Protected meal times have been implemented across adult inpatient areas.
- A blanket supplementary diet and comprehensive nutrition education is provided at ward level.
- Relationships established with primary care and voluntary organisations e.g. Carers and Alzheimer's societies.
- The Lead Nurse is the trust lead in Single Assessment Process implementation.
- The Lead Nurse has been instrumental in the development of the mental health liaison service for older people.
- Champions in clinical and non-clinical staff are being developed.
- The Lead Nurse is presenting at the 'Nursing and Older People Partners in Care' RCN conference in November.

**Evaluation**

- Our goals and objectives are being achieved.
- Audits in specific areas of work have been undertaken.
- The results from patient questionnaires are soon to be analysed and early indications are that there are now fewer nutritional complaints.

**Conclusions**

- Other disciplines are taking the lead role in integrating older people's needs within their training.
- Areas for development in a variety of settings are being highlighted and developed.
- The value of the Lead Nurse role in improving the overall experience for older people in hospital has been recognised and the trust has committed to making the post substantive at the end of the project.

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# Improving the Care of Older People Attending A&E

The ***Chesterfield Royal Hospital NHS Foundation Trust*** project was established to improve care provided to older people attending Emergency Care Services at the hospital.

**Aims**

- To improve the timeliness of access within the Emergency Care Directorate for all older people.
- To work with intermediate care and primary care to understand and utilise the services available to older people more effectively.
- To share this information with staff within the Emergency Care Directorate and act as a resource to enable the Emergency Care Directorate staff to access the services available in intermediate and primary care.

**Project Approach**

- *Access Coordinator Role*

We are currently in the process of piloting the Access Coordinator role, which will be undertaken by senior nurses working within the Emergency Management Unit. They assess all surgical GP referrals, following a strict referral proforma, discuss the appropriateness of the referral and offer alternatives to admission to the Emergency Management Unit. They also discuss current bed state information with the GP and when needed, will defer patients to the next day if agreed with the GP.

- *Clinical Specialist Occupational Therapist*

The trust was successful in obtaining monies to trial this role for a year within the Emergency Care Directorate. The aim of this role is to assess a patient's suitability for either a rapid transfer home, or to an appropriate care setting.

- *Intermediate Care Directory*

By working in conjunction with members of the Intermediate Care Team, we have been able to put together a resource file that lists all intermediate care services. This resource will be available in all local GP surgeries. It will also be available within the A&E Department and Emergency Management Unit at the Chesterfield Royal Hospital. It is envisaged that it will facilitate an earlier discharge to the most appropriate care setting for older people.

- *Rapid Access, Assessment and Treatment Team*

We are currently investigating the benefits of having a specialist multidisciplinary team within the Emergency Care Directorate. This would benefit all older people who require admission, assessment and treatment and ensure all patients are seen promptly and treated in the most appropriate care setting for the individual.

**Achievements**

The Access Coordinator role has proven to be successful with all surgical patients and it is planned to extend the scope for the Senior Nurses to take all GP referrals within the next couple of months. The flow within the Emergency Care Directorate has been much smoother, wait time and delays have been reduced and the trust has now achieved the four hour standard within A&E. Patients seen in the Emergency Management Unit following referral from their GP are seen quicker and the decision to admit or discharge happens within this unit.

The success of the Clinical Specialist Occupational Therapist role has shown that we are facilitating rapid transfer back home with extra support.

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# Many Pieces, One Goal

***County Durham and Darlington Acute Hospitals NHS Trust*** is a recently merged organisation covering a large geographical area with a higher than average population aged 65 and over. The trust has three acute sites and a number of community rehabilitation hospitals. Three Specialist Practitioners for Older People have recently been appointed to implement standard 4 projects, one based in each of the acute hospitals.

**Aims**

Our vision and aim is that "older people will experience the best care available, delivered by staff with the right knowledge, the right skills and the right attitude".

**Project Approach**

There are a number of ongoing projects linked to older people's services within the trust, the main one being a trustwide audit informed by:

- Essence of Care.
- End of Life Project.
- Nursing Collaborative.

Our involvement with these has been crucial in embedding these initiatives with an older person perspective and focus. A staff knowledge and skills audit tool and a patient carer satisfaction questionnaire for people aged over 65 years has also been developed. The results from the various audits and questionnaires will inform the direction and strategy for staff education. "Many Pieces, One Goal" suitably sums up our approach, with staff education being the dominant factor throughout.

**Achievements to date**

- The knowledge and skills audit and patient questionnaire has highlighted areas for staff training and development.
- The mandatory Health Care Assistant training is being increased to two days; half of the second day is focused around standard 4 of the NSF for Older People.
- A new competency framework and training programme is being developed for Health Care Assistants with standard 4 influencing a large part of this.
- Facilitating ward teams to improve their service using the Modernisation Agency PDSA cycle. This approach is being piloted on two older people's wards as part of the Nursing Collaborative project.
- Involvement in a countywide, inter-agency approach to vulnerable adults, including the development of a training strategy. Trustwide training will commence in January 2006.
- A Falls Strategy Group has been formed and falls prevention tools are presently being piloted.
- A successful quick fix is the pilot of the 'Red Tray System'. These trays act as an effective visual trigger, alerting staff that a patient requires assistance.

**Future Goals**

- Continuing development of educational resources and development of an intranet resource site.
- Working with teams to develop actions plans pending the results of Essence of Care audits.
- Reduce the number of older people being readmitted by exploring reasons and implementing measures.
- Implementation of a falls service on one of the trust sites.
- Formation of a Champions Network throughout the trust which will involve members from all areas.
- To continue with integration of the older person's perspective with other emerging initiatives.

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# Discharge Coordination: Older and Younger People with Dementia

Following concerns raised regarding the coordination of discharge from general hospital of older people with mental health problems, a joint bid for Standard 4 monies was submitted by ***Rotherham Primary Care Trust, Doncaster and South Humber Healthcare NHS Trust*** and ***Rotherham General Hospital Trust.***

**Project Approach**

A Mental Health Discharge Coordinator for older people and younger people with dementia has now been in post since June 2004. The main focus of the post is to work across partner organisations to fundamentally refocus the approach to the provision of services for older people with both physical and mental health problems and younger people with dementia on acute wards at Rotherham District General Hospital. The aim of the partnership is to improve the experience for older people with mental health problems and younger people with dementia admitted to the acute wards, by ensuring timely access to services to meet individual needs, which ultimately leads to timely and appropriate discharge.

Through advising, consulting and training with general hospital staff, the Mental Health Discharge Coordinator aims to reduce lengths of stay for older people with mental health problems on the acute wards. Close involvement in discharge planning enables more accurate placement of patients post discharge, reducing costly revisions of care packages, which in turn improves the patient and carer experience.

The Coordinator receives an average of 60 referrals a month from all members of the multidisciplinary team and works closely liaising with the Older People's Mental Health Team. The post provides a proactive service with a physical presence on the wards to assist and support staff when caring for older people with mental health problems.

**Achievements**

- Coordination of communication across the partner organisations has prevented delayed discharges and facilitated early diagnosis and treatment of mental health problems in older people and younger people with dementia.
- Changes to ward environment to improve the experience of for older people with mental health problems including visual signs and a nutritional screening tool for people with dementia to assist staff in establishing the level of supervision required during meal times.
- Piloting an integrated care pathway to facilitate transfer of patients between the acute trust and the mental health inpatient wards to improve communication and information sharing about the patient.
- The Discharge Coordinator has also been on the authoring group of an NHS Live Project to develop an information diary for people with dementia during their stay in hospital in an attempt to transfer the car they receive at home into hospital.
- A Breakfast Club has now been developed to promote independence, as a result of the training and education.
- A care of the elderly ward is looking to facilitate a reminiscence area in their day room.
- The project has recently reached the finals of the South Yorkshire PROUD Awards and received the Doncaster and South Humber Healthcare NHS Trust Chairman's Award for Outstanding Achievement in Older Peoples Mental Health.

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# Challenge Today to Change our Tomorrows

For the past decade, the ***Dudley Group of Hospitals NHS Trust*** had operated a model of care that aimed to treat all adult patients to the same standard, irrespective of age. Consequently there were no services designated specifically for older people. This resulted in an insufficient focus on the special and specific needs of older people brought about by the ageing process and related changes in social circumstances and lifestyle.

**Aims**

- To develop the knowledge and skills of staff to ensure they are able to identify, assess and meet the needs of older people, wherever they are cared for in the hospital setting.
- To improve the quality of care for older people wherever they are placed in the acute hospital setting.
- To transform the culture of staff across the acute hospital setting to ensure older people are valued and their beliefs and needs are better understood and acted upon.

**Project Approach**

The project commenced in June 2004 with the appointment of the first Clinical Specialist for Older People, a Registered Mental Health Nurse. Two part-time staff, an Occupational Therapist, with experience in both primary and secondary healthcare, and a Registered General Nurse with a background in rehabilitation joined the team later. This diversity of experience and knowledge has ensured that older people's needs are fully recognised and addressed by the team.

A staff survey was conducted across the trust to identify areas where staff felt further training was required. It was evident from the results that many staff of all grades and disciplines felt ill-equipped to give good care to older people with mental health needs, with 47% of respondents identifying a need for further training. The main thrust of the project therefore has been to address this gap in knowledge and raise general awareness of the specialist mental health needs of older people. The survey also highlighted a need for further training on the management of falls patients. This has led to the development of a Falls Risk Assessment Tool and associated Falls Prevention Action Plan which is now being piloted on selected wards around the trust.

By bringing together staff from the Mental Health Trust, the local branch of the Alzheimer's Society, and the acute trust, a training day was also developed which covers areas such as; what is communication; recognising anxiety and depression; and caring for people with dementia.

Whilst the Acute General Hospital and the Mental Health Unit have been geographically located side by side for many years, the working relationship between the two services has not been developed. However over the past year, stronger links have been forged due to the ongoing work of the Clinical Specialist for Older People to set up better channels of communication and establish closer partnership working.

In considering the patient's journey, it became clear that a certain group of older patients could be transferred directly from the Emergency Assessment Unit to the hospital's rehabilitation wards. A pilot scheme has shown that better placement of this group of patients can reduce lengths of stay, cut down on acquired hospital infections and facilitate speedier and safer discharges.

**Achievements**

- A training day is now available to all staff on a monthly basis via the trust's in-house training programme.
- Staff can now readily access support and advice from the Clinical Specialist for Older People in partnership with Old Age Psychiatry on the assessment and management of patients with significant mental health needs.
- The success of the Mental Health Liaison Service has led to more prompt and successful referrals of older patients and an appreciation amongst staff of the benefits of this to themselves as well as the patient.
- Ward-based Falls Prevention Awareness Training has commenced, and ways of incorporating training into existing mandatory training sessions are being explored. i.e. moving and handling training.
- The Falls Assessment Tool will be included in the revised admission documentation which is due to be implemented throughout the trust.

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# Standard 4 Change Project

The ***East and North Hertfordshire NHS Trust*** project commenced in October 2004, it has a project team consisting of two Facilitators, both with a nursing background, and a Project Administrator with excellent computer and graphics skills.

**Project Approach**

Ultimately, this project seeks to begin to challenge staff attitudes towards older people in hospital and promote a positive culture towards age awareness. This not only means the staff providing clinical care, but also the non-clinical staff such as housekeepers, volunteers and porters.

The Facilitators are using a variety of teaching approaches and information giving resources, to begin to promote a shift in cultural change. Training and development is evaluated by the staff who attend the sessions.

Training material for Safeguarding Adults from Abuse has been developed. In September 2005 awareness workshops will commence across the trust for all staff, including those that have informal contact with patients such as volunteers, chaplains and Age Concern staff. The outcome of these workshops will not only provide a forum to inform staff of Adult Abuse policies and procedures, but will also challenge behaviour, attitudes and communication approaches with older people.

**Aims**

- To achieve a better overall experience for older people in all clinical areas across the trust.
- To ensure that older people’s care is delivered by hospital staff that have the right set of skills to meet their needs.
- To ensure sustainability of changes in older people’s care, therefore promoting effective service delivery for now and the future.

**Achievements**

- Dementia Care Training workshops have commenced. These one hour workshops are supported by a Carers Support Worker from the Alzheimer’s Society. Other dementia care training opportunities are currently being developed.
- Ward Hosted teaching sessions have been undertaken encompassing a variety of topics about caring for older people, such as nutrition, age awareness and NSF standard 4 information.
- A successful user involvement survey was carried out, in conjunction with PALS, at one hospital site and the results disseminated through PALS reporting procedures.
- Other training programmes, such as the Mandatory Drug Administration Update and Preceptorship Programmes, now have a session which incorporates issues for older people’s care.
- The project produces a regular Standard 4 Change Bulletin for trust staff, and copies can be downloaded from the NSF Standard 4 page on the trust intranet site.
- Development of a bedrail audit tool, as part of a clinical governance project to reduce patient falls from bed.

**Future Goals**

- To produce more educational resources to cover topics including older people’s care, age awareness and adult protection.
- To deliver a programme for dementia care.

**Conclusions**

The Standard 4 Change Project is proving invaluable for all levels of staff across the organisation, providing them with the opportunity to discuss and collaborate on older people’s care issues.

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# 4 Ward Together

Getting the basics right is at the heart of the Standard 4 Project at ***East Somerset NHS Trust***. The project is focussed on raising staff awareness and improving their knowledge of older people's issues using a simple and practical approach.

**Aims**

- To provide readily accessible training in a variety of formats and reach all members of our workforce.
- To engage a body of key people to ensure the needs of older people are met, and that staff are well supported.
- To make small changes to the environment and systems that make a big difference.
- To listen to the voice of older people in hospital and staff.

**Project Approach**

- Having completed a skills profile of staff in relation to the care of older people, 'bite-sized' information and education sessions have been established and delivered at ward handovers and departmental meetings. These are given by in-house staff skilled in chosen topics and include; hearing loss; spiritual needs; communication; respiratory issues; falls; walking aids; Parkinson's Disease; PALS; continence and cognitive impairment. Time demands are small both for staff and speakers. Sessions will be backed up by pocket sized fact cards which will also become available through the staff induction process.
- A network of Older People's Champions has been established across the trust. Staff who have volunteered for the role come from a variety of backgrounds and are responsible for dissemination of information and are advocates for older people.
- One of the trust's Therapy Advisers has been able to focus on managing falls within the hospital environment. Recognising that falls are common among older people in hospital recovering from acute illness, we are piloting the STRATIFY falls risk assessment tool to try and identify those at risk of falling to ensure timely and appropriate management can be put in place. The outcome will be presented to Clinical Governance later this year with the intention of introducing the tool trustwide before the end of the project.

**Achievements to date**

- The Older People's Champions have been given additional support so far by volunteer Champion Forum members and two 'away days' have been enjoyed focussing on 'Communication' and 'The Champion's Role' . In total 28 champions have been recruited, including a Non-executive Director, with the hope that they will continue the work after the project ends.
- A number of 'quick fixes' have already been identified. These are small, practical changes that make a big difference to an older person's experience in hospital. Through funding from the League of Friends, special amplifiers have been installed for the hearing impaired and adapted cutlery has been provided on every ward. In addition simple and easy to read clocks have been purchased and fitted in all key hospital areas.
- To gain a true understanding of what older people want, staff ask them. Loneliness has been highlighted as a key issue which has resulted in 'Time for You', a scheme staffed by volunteers who come into hospital and spend time talking to older people.
- In conjunction with the Somerset Academy, falls education has now been provided for staff and a Falls Home Exercise Programme is almost complete.

**Conclusions**

Because of our layered, simple and practical approach all the team have been able to give rapid access advice at timely moments to reinforce our commitment that older people receive the maximum benefit from having been in hospital. Staff are actively encouraged and have the confidence to adopt a more deeply rooted older person's perspective for general hospital care.

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# Partnership in Practice - Mental Health Liaison in Gloucestershire

The national concerns about service improvements for older people with mental health needs in general hospitals led Gloucestershire Local Implementation Team to identify this area as a priority for investment Following a successful bid for Standard 4 NSF monies, the Mental Health Liaison and Education Project began at the ***Gloucestershire Hospitals NHS Foundation Trust*** and the ***Gloucestershire Partnership NHS Trust*** . Two Mental Health Nurses with clerical support were appointed to train and support staff across the whole hospital to improve the recognition of mental health problems through education and training.

**Aims**

To ensure that older people receive the specialist help they need and that staff are enabled to provide specialist care for older people with mental health problems, bridging the gap between general and mental health services.

**Project Approach**

Due to the nature of the project and the large number of wards involved, we adopted a consultative and advisory model. We attended ward rounds, handovers, ward meetings and generally worked alongside and communicated with staff. Interactions with staff helped to inform us of the needs and difficulties of managing and treating older people with a mental illness in a general hospital setting. These interactions were also viewed as opportunities for teaching and a number of referrals were generated from this method. The referrals then guided the content of our teaching as case studies and the establishment of training programmes. All referrals were viewed as potential teaching opportunities and to encourage staff confidence in using us, we reinforced to all staff that there was no such thing as an inappropriate referral.

**Achievements**

- There have been 185 referrals across two hospital sites, 90% from the rehabilitation service. Problems varied but patients with suspected dementia and depression formed the highest number.
- Formal teaching has been delivered through training days, workshops and visits to mental health settings. These focused on person-centred care using case studies from the referrals and were therefore evidence based. These are constantly reviewed and evaluated.
- Opportunistic informal teaching occurs on a one to one basis with health care staff about individual patients and we have been able to act as role models to staff when necessary.
- We have established good links with the mental health teams in order to encourage joint working.
- We have gained acceptance as part of the multidisciplinary team and have had involvement in case conferences where appropriate, raising the profile of mental health and older people.
- A core care plan has been developed in order to detect depression, based directly upon our observations and referral content.
- A draft referral pathway for people experiencing mental health problems within the trust has been proposed.
- We have had a poster accepted by the Mental Health Liaison and Older People Network and this was displayed at their Leeds conference.
- We were invited to deliver a presentation by the National Institute for Mental Health in England at their conference as an example of good local practice.
- Educational materials that we have produced have been accepted onto the Change Agent Team website.
- We have established links with the University of Worcester to develop a multidisciplinary workbook. We have also been asked to advise on mental health and older people for pre-exiting courses run by University of the West of England and the NVQ teaching programme.

**Conclusions**

This project has raised the profile of mental health and older people's care in general hospital and brought it into mainstream discussion and debate within this setting. In doing this we have begun to get general health care staff to acknowledge the complexity of this client group. Through our flexible training method approach we have supported staff in providing holistic care.

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# The Development of Dementia Care in a General Hospital Setting

Local information and national evidence suggests that the acute hospital care provided for patients with dementia and/or acute confusion (delirium) has scope for improvement[1,2]. Acute confusion affects up to 30% of all older medical patients with associated high mortality rates, complications and longer lengths of stay in hospital. In addition, Professor Ian Philp, National Director of Older People's Services and Louise Appleby, National Director for Mental Health, stated in '*Securing better mental health for older people',* that 'main-streaming' of specialist mental health input was required due to the complex needs which cross service boundaries for people with living with dementia.

The ***Homerton University Hospital NHS Foundation Trust*** project is testing methods of improving acute hospital care for patients with dementia and/or acute confusion.

**Aims**

- To examine how far the new clinical role of Dementia Care Assistant can influence and improve the quality of hospital care provided to patients with dementia and acute confusion.
- To assess whether the techniques developed by the Dementia Care Assistants can be transferred to other parts of the hospital through education and training.

**Project Approach**

- The delivery of direct person-centred dementia care via two full-time Dementia Care Assistants working with a staff team on a 28 bed acute elderly care ward. This clinical work is supervised by the Consultant Nurse for Older People.
- Mapping where patients with dementia are cared for within the organisation and consulting with staff concerning the delivery of person-centred dementia care.
- An in-depth dementia care developmental programme has been developed for two clinical teams with identified developmental needs in this field.
- Implementation of locally developed guidelines for the delivery of effective dementia care across the organisation.
- Dementia care awareness for all hospital staff via the hospital induction system.

**Achievements**

- Establishment of a project steering group chaired by the Director of Nursing.
- Establishment of a Dementia Care Team with improved links with mental health providers.
- Audits undertaken on the quality of interaction between staff and patients (QUIS tool).
- Extensive education and training provided for clinical staff, with feedback of greater staff knowledge and awareness in this field.
- Improved quality of care provided to vulnerable and frequently challenging patients, evident through reduced formal and informal complaints.
- Presentations made to the Nursing and Midwifery Board, clinical governance meetings and Governors AGM.
- Review of a number of delirium/dementia clinical care guidelines with current activity on adapting guidelines to our local care practices.
- Article published in hospital staff magazine.

**Conclusions**

The discreet product from this project is an evaluation of a new clinical role (Dementia Care Assistant) to improve care for older people in hospital.

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[1] Help the Aged (2001) Dignity on the ward Improving the experience of acute hospital care for older people with dementia and confusion
[2] Department of Health (2001) Essence of Care Patient Focused Benchmarks for Clinical Governance

# Developing a Vision of a Modern Quality Service for Older People

The appointment of a Project Manager for General Hospital Care coincided with a proposed new build for Medical Elderly Services at the Hull Royal Infirmary site. Although the new build has now been postponed, it was agreed that the project would continue with a remit to ensure that older people in the Hull and East Yorkshire region received the best possible care. The ***Hull and East Yorkshire Hospitals NHS Trust*** project therefore commenced in November 2004.

**Aims**

The fundamental goal of the project is to ensure the full compliance with the NSF for Older People and that the patient experience is of high quality. Taking the key themes of the NSF, the project was structured around:

- Emergency response
- Early assessment
- Ongoing care in surgical and general medical wards
- Old age specialist care
- Discharge planning

**Project Approach**

A Project Board and steering group were established with the steering group reporting to the Board on a bi-monthly basis. PRINCE2 methodology was used to manage the project. As part of the communication strategy, the Project Manager developed an intranet site for the department where pages dedicated to the project were used to keep the wider audience informed.

A pathway audit lasting four weeks was undertaken to identify areas that would benefit from modification. We used the audit analysis to formulate a plan to implement remedial action. This included the implementation of the project's Estimated Date of Discharge and Nurse Led Discharge guidelines. Teaching packs have also been produced.

A skills audit of staff working with older people has been commissioned for the months of August / September 2005. The intention is that the audit findings will be used to inform the educational strategy of key stakeholders.

It became evident in the early stages of the project that existing work streams would be a useful resource and so links were quickly established with orthopaedics and their discharge planning project. In conjunction with the Acute Assessment Unit Team the project aims to establish a slicker more responsive emergency assessment for the older person. Our community partners have joined our efforts in creating a seamless service between primary and secondary services.

**Achievements**

- A reduced length of stay that has been sustained without detriment to the patients experience and quality of care.
- We are currently writing our *'Vision',* outlining our short, medium and long-term plans for the evolution of services for older people in the Hull area.
- Guidelines have been produced for 'Self Medication', 'Nurse Led Discharge' and a 'Skills' audit tool. The skills audit is due to end in September 2005.

**Conclusions**

It could be argued that the NSF for Older People is all about standards of care. However, in Hull, we are trying to capitalise on the impetus and interest the project has generated. We want to modify the culture and attitude towards caring for older people. We feel strongly that this is just the start of a longer journey that will see caring for older people take centre stage in the community as well as the acute trust.

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# Caring for Older People in an Acute Hospital Setting

The original aims and objectives of the ***Ipswich Hospital NHS Trust*** project were to ensure that older people receive the specialist help they need in the hospital and that they receive the maximum benefit from their stay. This was to be achieved by ensuring that we have an educated workforce in relation to the care of older people in an acute environment. To attain this we decided to recruit an individual to undertake the work over a two year period, however, after numerous attempts with recruitment we realised that we were not going to be successful. The Department of Health encouraged us to think innovatively and focus on exactly how we were going to achieve this and a different approach has now been adopted.

**Partnership working approach**

A Consultancy which has worked extensively with both the trust and SHA has been commissioned to work with us to deliver the project. The project has been broken into seven phases: planning, identifying internal and external training provision, skills analysis profiling exercise, development of a competency framework, developing a framework for the delivery of education and training, identification of key individuals to deliver the training and education, and a robust evaluation process.

**Project outputs**

The active phase of the project is in its early stages (starting on July 1st 2005) and is working to a very tight schedule. However, the first two months have been very productive.

❖ *Competency Framework* - The key principles in undertaking this task were to:
  - Avoid duplication of other initiatives, such as the KSF.
  - Concentrate on areas specific to older people or most relevant to the care of older people.
  - Create a framework that would be easy to understand and use.

An analysis of key documents was then undertaken including:
- Older People's National Workforce Competence Framework
- KSF
- National Occupational Standards and Qualifications for Health and Social Care
- National Occupational Standards in Mental Health
- Emergency Care National Workforce Competence Framework Guide.

From this analysis, we formulated competencies for the Ipswich Hospital competency framework, based on the key principles we established at the outset. After a process of validation and consultation, we produced 14 competency statements, each of which has a number of indicative statements.

❖ *Competency Analysis Instrument* - Building on the competency framework, we were able to create a diagnostic instrument to assess the performance of job groups and service areas in the trust against this framework. This competency analysis instrument has been designed to assess the general performance of a group of people, not the performance of individuals. It requires individuals to rate the general performance of their colleagues against 66 indicative statements. It can be administered individually or in groups, and can be completed on paper, on-line, by email or, in groups, by using special hardware and software to create instant group response profiles. It takes about 30 minutes to administer the instrument to an individual or group.

There are already some useful outcomes from the project. In particular, we have begun to:

❖ Explore and analyse the approach to workforce education in the trust.

❖ Build links with other trusts and other NSF projects.

❖ Raise awareness of the needs of older people among the trust workforce.

**Going forward**

In the final six months of the project, we will:

❖ Continue to use the competency analysis instrument to analyse the performance of the trust workforce.

❖ Use the competency framework to improve delivery of workforce education and training around care for older people.

❖ Develop an evidence-based process to evaluate workforce education and training in the trust

❖ Share learning and good practice with other trusts.

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# A Multidisciplinary Project Focusing on Older Patients' Needs

Two out three patients in the ***King's College Hospital NHS Trust*** are aged over 65. Staff in all wards should possess the skills and knowledge to address the specific needs of older patients. We are working to improve care for our older patients, with the patients themselves playing a central role in our joint effort.

**Project Approach**

- To identify what older patients think we should do better via structured and semi-structured interviews, workshops and discussions with patient partnership groups and individuals.
- To identify what our staff feel we could do better via open and semi-structured interviews, questionnaires and group discussions.
- To address the identified needs and gaps in our service via qualitative and quantitative analysis of data, trustwide audits and other sources of information including:
  - Essence of Care audit
  - Observations of care audit
  - Patient survey results
  - Patients' complaints
  - Risk office data and general data of readmissions
  - Discharges
  - Results of treatment
- To benchmark and verify our results, a literature analysis was of training needs identified by other projects was conducted, as recommended by the NSF for Older People and other research data.

**Achievements**

- Consultation was held with a wide variety of community groups (pensioners' groups, carers groups, voluntary groups and older people from different ethnic and social backgrounds) to identify gaps in our service and what we can do better.
- A formal trustwide staff skills audit was undertaken across all wards and clinical areas with staff at all levels and from all professional groups. The aim of the audit was to identify perceived training needs and non-training interventions that would help to provide better service for our older patients across the trust.
- A multidisciplinary team was selected to drive the project forward with leading roles given to three former patients. This group coordinates the direction of the project and its dissemination, ensuring that the needs of older patients remain central to the project.
- Strong working links were established with local PCTs, the Trust Board and other relevant initiatives across the trust and in the community.
- E-learning interactive modules, to address the identified training needs, were developed by King's College Hospital experts in multidisciplinary teams with academic input from King's College London. The modules are available for all trust and local PCT staff. They are linked to the Knowledge and Skills Framework (Agenda for Change) competencies and are incorporated into the essential recommended professional development portfolio of the trust. Each of the topics is an intranet/CD-rom based interactive, patient-centred module with videos and practical case studies. The e-learning modules include the following topics:
  - Communication
  - Person-centred care
  - Immobility and falls
  - Incontinence
  - Discharge planning
  - Dementia
  - Depression
  - Challenging behaviour
  - Prescription in old age
  - Comprehensive assessment of an older person
  - Nutrition and hydration
  - Rehabilitation of older clients
  - Palliative care and older people
- The project results were communicated via a number of publications, conference posters and presentations to country-wide professional groups, community user groups, PCTs and local Social Services.

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# Organisational Development Coach

The ***Lancashire Teaching Hospitals NHS Foundation Trust*** project focuses on the introduction of an Organisational Development Coach into the acute trust, as well as two Primary Care Trusts in Central Lancashire.

**Aims**

- To undertake a holistic assessment of 'real' progress made in implementing the NSF for Older People.
- To change behaviour and attitudes of staff by developing skills and knowledge in caring for older people 'on the job'.
- Empowering staff to continually develop the service and implement change that will benefit the patient.
- To improve patient satisfaction levels and clinical outcomes.

**Project Approach**

- Orientation and familiarisation with the objectives of the NHS, the NSF for Older People, the trust, national and local drivers, barriers and opportunities for service development and identification of key stakeholders.
- Networking with local key influencers and drivers.
- Meetings were held with Senior Personnel to discuss the project; the role of the Organisational Development Coach; ethical practice; processes; reporting mechanisms and identification of any particular issues or concerns.
- Meetings with staff groups are likely to be observed.
- Observations of practice in wards, clinics and community settings, to include:
  - *Detailed observation* - working shifts, listening to and shadowing patients, observations of ward/bay/clinic activity, therapeutic and escort services, diagnostic appointments, domiciliary visits, case conferences and multidisciplinary team meetings.
  - *Detailed oral and written feedback* - dissemination of best practice, identification of areas for development at both micro and macro levels, recommendations for service developments, planning and delivery of future coaching, learning and development interventions.
  - *Revisit and observation* - identification of service development and next steps.
- Dissemination of findings into key forums/personnel.

**Achievements**

- Increased awareness amongst staff of language as an enabler or inhibitor and increased use of inclusive language.
- Increased environmental scanning by staff and changes to the physical environment.
- A flexing of services to reduce waiting times for diagnostics.
- Increased patient involvement in menu design, planning and taster sessions.
- Heightened awareness of the NSF for Older People across the trust, with specific attention to staff attitude towards patients.
- Development of service standards for the Medicines Management Team.
- Implementation of staff development activities e.g. Patients as Partners and Protecting Older Adults from Abuse.

**Conclusions**

To date, the main conclusions from the project are that minor changes to service design, environment and interpersonal practice can make significant improvements in a patient's experience. Research needs to be undertaken to assess the effectiveness of coaching in enhancing the patient experience, clinical outcomes, staff morale and the overall quality of service design and delivery.

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# Orthopaedic Older Persons Project

The Orthopaedic Trauma Unit at the ***Leeds Teaching Hospitals NHS Trust*** was chosen to receive an elderly medicine liaison service as the rate of referral from this unit was the greatest in the hospital. Over the last three years three Consultant Orthogeriatricians have been appointed and they provide a liaison service to the orthopaedic trauma wards in conjunction with the services of the Orthopaedic Older Person's Specialist Nurses. These roles have been developed to combine the orthopaedic and generic needs of older people for these patients and to ensure that a combined service is delivered via this Orthopaedic Older Person's Team.

**Aims**

- To provide a liaison service from the Orthopaedic Older Person's Team.
- To promote an excellent level of care for older people by educating staff in the special needs of older people.
- To develop links with other services such as Mental Health, Social Services and Intermediate Care Teams.
- To improve this service through the development of a dedicated Older Person's Orthopaedic Trauma Unit due to open in March 2006.

**Project Approach**

- The Consultant Orthogeriatricians undertake ward rounds three times a week where patients receive a specialist review. The Consultants also attend weekly multidisciplinary team meetings.
- The Specialist Nurses monitor the standards of care delivered in accordance with the standards defined in the NSF for Older People and the National Benchmarks for Essential Care.
- The Specialist Nurses identify best practice and act as expert clinical role models, champions and educators.
- Process mapping, patient dairies and patient walkthroughs identified present practice in the patients' journey.
- The Orthopaedic Older Person's Team has contributed toward the development of a national hip fracture database.
- A variety of methods have been employed to promote staff education and training in the special needs of older people in preparation for the new Older Person's Orthopaedic Trauma Unit.

**Achievements**

- Reduced length of stay for patients with complex discharge by ten days over a two year period.
- Osteoporosis screening and management implemented.
- Falls assessment and management implemented.
- The Orthopaedic Older Person's Team is developing a Hip Fracture Care Pathway.
- Pathway work includes patient diaries; process mapping; patient walkthroughs and issue logs.
- Improved links forged between primary and secondary care and with social care agencies during pathway development.
- Audit review of ward areas carried out.
- Improving pain management through benchmarking and education.
- Nutritional benchmarking has been undertaken, resulting in alterations to meal times and service delivery.
- Links with the new Mental Health Liaison Team developed with staff education a priority.
- Single Assessment Process documentation has been trialled and implemented citywide.

**Conclusions**

Care for older orthopaedic patients will be best managed on a specialist unit. The plans are for an Orthopaedic Older Person's Unit based on three wards, on one site. This will enable the Consultant Orthogeriatricians to assume the role of day to day management of these patients at an appropriate post-operative stage, rather then as a liaison role. A specialist multidisciplinary team trained in both the surgical, medical and social needs of older people will be established.

Ways of transferring this model of care to all older people on general wards within the trust are being explored, with plans to develop a liaison service to the vascular and urology wards.

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# *Spreading the Word: The Impact of Good Communication*

The ***Mayday Healthcare NHS Trust*** project focuses on two areas of improving communication: raising awareness of the unique needs of older people by providing staff with practical communication skills to reduce confusion, anxiety and delay in the patient's stay and; supporting a fundamental improvement in the care of older people on medical and surgical wards through the provision of more proactive planning of patient care and timely access to the specialist services available in Croydon. The overall aim is to ensure that older people elsewhere in the hospital receive the same high quality of care as those in the elderly care wards.

**Aims**

- Better understanding of staff attitudes to elderly care.
- Benchmarking of reasons for delays in patient journey.
- Improving communication skills of all staff.
- Better understanding in medical and surgical wards of the older person's experience.

**Project Approach**

- *Identification of Communication Gaps* - By mapping a series of patient communication pathways, the trust is able to identify the key points which impact on a patient's length of stay. The trust may then use external expertise to improve communication in these areas.
- *Implementation of Link Clinicians* - to improve knowledge of the support services available for older people, to facilitate access to these services at the appropriate time. The Link Clinician acts as a focal point on each ward to support the dissemination of information about new initiatives and services. They are also responsible for reinforcing the project's learning i.e. encouraging the identification of the needs of older people and implementing communication skills. It is important that the Link Clinicians help staff to reflect on how slight modifications in behaviour can dramatically improve the patient's experience whilst in hospital.
- *Creation of Clinical Leads for the Project* - ***to*** provide credibility with clinical staff and ensure dedicated clinical input into the project.
- *Improved Dissemination of Specialist Services Available* - Confusion about the roles of different services external to the hospital currently leads to inappropriate referral and poor experience for patients. A priority action in the new proposal is the creation of information folders for each ward providing clarity around the services available to older people outside the hospital.

**Achievements**

- Agreement by the Complex Planning Group to pilot the Link Clinician role in medical, surgery and elderly care wards and the first draft of the Link Folder has been created.
- An Open Space Event for older people looking at the older person's experience of hospital has been held. This gave older people the opportunity to discuss areas for improvement and prioritise which areas they felt required immediate attention. Outcomes from the day were also used in drawing up benchmarks, against which we will monitor the project.
- A more accurate and systematic collation of delayed discharge information enables accurate monitoring of, and reasons for, these delays.
- A Patient Experience Questionnaire is being piloted on two hospital wards.
- A Communication Audit has been commenced to determine which aspect of communication will have highest impact on improving patient experience. Early evidence suggests one area of focus should be information regarding the day and time of discharge from hospital.
- Development of communication training.

**Conclusions**

Whilst the project is still in its early stages, it has been enthusiastically received by patients and staff alike.

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# *Time to Challenge Acute Hospital Care: An Education Initiative*

In 2003 ***Medway NHS Trust*** conducted a trustwide review of achievement against standard 4 of the NSF for Older People. Results highlighted under provision of specialist hospital care for older people by appropriately trained staff. Contributory factors included insufficient training available focusing on older people and efforts by nursing staff to attend statutory and mandatory training. In response to these findings, an education initiative was developed at the trust to modernise hospital care for older people.

**Aims**

- To the deliver better health care and improve the hospital experience for older people.
- To raise the profile of gerontological nursing through awareness promotion strategies.
- To develop an educational programme specifically focusing on the older person.
- To celebrate our valuable contributions towards achieving modernised hospital care for older people.

**Project Approach**

A team dedicated to developing older people's services has been established. The Project Lead is a newly appointed Older Persons Modern Matron with support from a Practice Facilitator (a seconded Older Person's Ward Manager). The Modern Matron role includes leadership to enable service developments ensuring local and national strategies are successfully implemented whilst raising the profile of gerontology and acting as an advocate for older people. The trust's campaign to modernise older people services identifies four key themes:

- Education.
- Raising awareness across the trust.
- Developing an Older People Champion Network.
- Celebrating our successes and sharing best practice.

**Achievements**

The development of an educational programme exploring gerontology issues has improved service provision for older people by raising awareness, providing participants with evidence based knowledge and ultimately encouraging opportunities to challenge practice through dissemination of information. A number of approaches are being used:

- A one day programme has been introduced dedicated to raising awareness of the NSF from a multi-professional perspective. The two events held so far have been positively evaluated and future audits are planned to monitor the sustainability and effectiveness of the programme.
- An extended course is now planned in response to the feedback received. Unfortunately, we have not been able to secure academic accreditation from a linked university due to the complications of ownership.
- Short teaching sessions are occurring trust wide to raise awareness.
- A poster campaign has been developed and delivered across all trust directorates. This highlights the importance of valuing older people in relation to NSF standards and celebrates the first two educational events.

A Non-executive Director acts as the trust Champion for Older People and we are currently in the early stages of developing an Older Person's Champion Network to which all trust staff will be invited.

We will be sharing our dedicated website across internet and intranet sites and have celebrated our successes through local and national networks, publications and presentations, including sharing at the next trust Annual General Meeting.

**Conclusions**

The campaign has been a great success and this had led to the development of new ideas that will contribute to the delivery of seamless high quality health care for older people at Medway. The profile of gerontology and awareness of older people's issues has been increased both within the trust and external community. A structured approach has been developed ensuring older people are cared for by appropriately trained staff. The future presents an opportunity bursting with potential and on completion of the project it is envisaged that a new Professional Development Nurse role will be identified to continue the excellent work commenced during the campaign.

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# Older Peoples Partnership Project

Staff at the ***Mid Yorkshire Hospitals NHS Trust, South West Yorkshire Mental Health NHS Trust*** and **North Kirklees PCT** have been working together to deliver the Older Peoples Partnership Project which has two elements:

- A dedicated team of mental health educators who work alongside staff within all wards and departments of the Dewsbury District Hospital.
- Twelve acute trust champions, who are trained in the use of the Dementia Care Mapping Tool, evaluating person-centred care in each of the clinical areas.

**Aims**

The purpose of the project is to improve care by providing holistic, person-centred care for older people with mental health problems such as anxiety, depression and dementia in the acute hospital setting.

**Project approach**

- Active care and action planning to facilitate a partnership approach involving the multidisciplinary team, patients, family and carers.
- Champions to keep reflective diaries to record positive events and changes to practice within each clinical area.
- Clinical areas have been part of the evaluation process using the Dementia Care Mapping Tool.
- Benchmarking person-centred care.
- Three action learning sets for differing levels of staff focus on education, clinical supervision and therapeutic activities.
- Practical training through implementation of a rolling education programme.

**Achievements**

- Six clinical areas have been part of the evaluation process using the Dementia Care Mapping Tool. Each area now has an action plan for a six month period, with an annual mapping programme.
- Champions have been involved in this process, facilitating change within their own area by educating colleagues and using skills to develop agreed care plans, individual care summaries and group therapeutic activities.
- Mealtimes have been mapped to improve the quality of experience for older people.
- We are piloting a form template which care homes complete when their patients are admitted to hospital. This is to provide A&E staff with information about the person relating to issues such as communication.
- The project is working with carers and older adults to compile an interactive CD-rom with 20 training sessions and activities on it. The contents will also go onto the trust website for staff to use.
- Life history documentation is being utilised in all clinical areas, as well as reminiscence group therapy for patients.
- Staff have been trained to use relaxation and breathing exercises with patients who are experiencing anxiety.
- The porter and catering department's champions have developed their own charters, including a set of ten standards they identified as important to improve the journey of older people.
- The education programme consists of full study days with guest speakers, 20 micro sessions delivered on the wards, clinical team learning contracts and one hour study lectures in the education department. Students are also targeted through small placements with the team and the training status we have, enabling students to spend a six week placement with us.
- We benchmark person-centred care in each clinical area, and facilitate action planning.

**Conclusions**

The most important outcome and consequence of this project has been the strong link forged between the partner organisations.

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# HALT! Is that an Older Person?

HALT *(Hearing And Listening Together)* is a project at the ***Milton Keynes General Hospital NHS Trust*** that links the improvement of services for older people to staff development and the practical implementation of two Department of Health documents; NSF for Older People (standard 4) and Essence of Care.

**Aims**

Milton Keynes, a 460 bed district general hospital, has a policy of integrating care of the older person on all wards. Patients are currently being transferred to a specific PCT ward for the elderly, only if there is a problem with their mental capacity and only if there is space available on the ward. Quality of care for the older person within this setting and implementation of the Essence of Care Standards are therefore central to the HALT project aims:

- To ascertain how necessary and practical a specific ward for elderly patients in the hospital would be.
- To raise awareness, knowledge and skills in staff with regard to caring for the older person throughout the hospital.
- To support, where necessary, a change in attitude and philosophy of care with regard to the older person in the acute care setting.

**Project Approach**

The HALT project is primarily bottom-up and decentralised, linking care of the older person to activities already being undertaken. These activities include audits and implementation of the Equality and Diversity policy, right through to issues pertinent to users, representatives and ward staff. In order to link the project to the reality and perception of all parties concerned, information was collected as follows:

- Area/Ward related; interviews with ward managers and discharge coordinators.
- User representation; focussed interviews with recognised groups representing users.
- Patient representation; informal discussions with patients related to their satisfaction of the service provided.
- Complaints lodged by patients aged over 66 years.

**Achievements to date**

- Information has been obtained from patient representatives and users with regard to their satisfaction of the service the hospital provided.
- Staff have identified the knowledge and skills they need to care for the older person.
- A literature review has been conducted in relation to; the needs identified by staff; results of informal interviews with users about their satisfaction of the service provided; and formal complaints lodged by the over 66 age group. This has provided more insight for stimulating discussion with regard to establishing a specific ward for the older person within the hospital and is currently being compiled as a publication.
- Collaboration with clinical governance has resulted in existing audit instruments being extended to include age. This will allow further age related data to be gathered, analysed and used in management and education within the hospital.
- An education programme has been developed, providing an integrated, holistic care approach to staff in which all teaching sessions incorporate aspects of philosophy, clinical and moral decision making and evaluation.

**Future goals**

- A change in attitude, philosophy and quality of care is not something that can be evaluated comprehensively in the short term alone. The impact of the HALT project will be evaluated over time incorporating user feedback, staff perspectives, ongoing audits and patient outcomes.
- In the short term the educational programme starts in autumn 2005 and is aimed at improving awareness, knowledge and skills.
- An ongoing support programme relates care of the older person to the concept of Equality and Diversity within the hospital.
- The ward managers are encouraged to name a champion in each department/ward. These champions will be supported in setting out an action plan, implementing change and disseminating knowledge in each area.

**For further information contact:**

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# Newham Standard 4 Project

The ***Newham PCT*** and ***Newham University Hospital NHS Trust*** project was seen as a natural progression from the developments started by the Newham Older People's Partnership Board, which includes the health, social and voluntary sector, with older people's representatives, and the service improvements implemented through working with the London Older People's Collaborative.

**Project Approach**

The Care of the Elderly Unit at Newham University Hospital is transferring to a new build in 2006 and this project compliments our aim to provide 21$^{st}$ Century care in a 21$^{st}$ Century environment through three sub-projects:

- Training and development of a specialist Older People's collaborative team.
- Development of an integrated response to older people's mental health needs in the acute sector.
- Development of case management based on the work started with the London Older People's Collaborative.

Two members of staff were recruited to work on the project: an NSF Co-ordinator and a Case Manager.

**Achievements to date**

❖ ***Training and development of a specialist Older People's collaborative team***

A skills audit was designed in collaboration with a multidisciplinary team and executed online. This has identified the training needs and a multidisciplinary training strategy is in the process of being devised.

❖ ***Development of an integrated response to older people's mental health needs in the acute sector***

A mental health needs audit was carried out based on Standard 7 of the NSF. This involved joint working with the Mental Health Trust to review protocols for appropriate care and placement for patients with confusion and dementia. The outcomes were fed into transfer planning and design groups.

❖ ***Development of case management based on the work started with the London Older People's Collaborative***

The Case Management Service for Older People with Chronic and Long Term Conditions is a new service provided by the PCT and involves the case manager working across boundaries in the acute, primary and social care sector. The project aims to reduce the number of avoidable admissions for people with long term and chronic conditions by:

- Identifying patients suitable for case management using case management criteria.
- Working with patients providing social and clinical services.
- Categorising patients and working in collaboration with other long term condition services ensuring that patients are at the correct level of the Health and Social care model.

It also aims to provide a service which allows these patients to experience a seamless journey through the health and social care system.

It was intended that 15 patients should be case managed during the project with the main outcome being to reduce avoidable hospital admission and A&E attendance for these individuals.

- Six months into the project 14 patients are being cased managed, and
- A review of three of the patients has shown a reduction in admission and A&E attendance.

**Future Plans**

❖ The Case Manager will continue and develop the work started with The London Older People's collaborative.

❖ The NSF Coordinator will:
- Lead on service improvements.
- Complete the required analysis of audits.
- Develop an integrated response to older people's mental health needs in the acute sector.

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# *Inpatient Falls Strategy*

An analysis of inpatient accident reports at ***Northumbria Healthcare NHS Trust*** identified falls as a major factor. The highest level of falls occurred on the elderly acute wards, orthopaedic wards and the community rehabilitation wards. In response to this, an Inpatient Falls Strategy has been developed.

**Aims**

- To reduce the number of inpatient falls.
- To promote best care for those who did fall.
- To provide an accepted pathway for falls patients in Emergency Care.
- To educate all staff on the importance of falls to include:
  - the effect it has on the patient,
  - the effect it has on the organisation,
  - the importance of correct care.

**Project Approach**

A flow chart based on a traffic light system and incorporating a multidisciplinary approach was developed for those patients admitted to Care of the Elderly wards following a fall and also for those who fell as an inpatient. The falls assessment document was based on the document already in use within the trust, and a plan of care to tie in to the traffic light system was created. An information booklet for patients was designed and a health promotion area and leaflet display was created.

Accident reports are the primary means of assessing the strategy's effectiveness, however we also designed a personalised falls log to identify repeated fallers and test the sensitivity of the falls assessment. A pilot implementing the falls strategy is planned to run for three months.

Two acute elderly care wards and two rehabilitation wards were selected to pilot the project, and staff education sessions have been held. Project Managers have visited at regular intervals to address queries and provide support.

On one site, a Nurse Practitioner interested in falls developed a separate flow chart specifically for those attending Emergency Care. This was also based on a traffic light system and designed to ensure falls patients were triaged appropriately and anyone referred to the Falls Outpatient Clinic had already had baseline bloods and other relevant investigations.

**Achievements**

- During June (a time when much of the teaching and awareness raising was going on) there were 16 reported falls on one pilot site compared to 23 in the previous month.
- The strategy has raised awareness of falls and managers on non-pilot sites are asking for advice on falls prevention.
- The leaflet area is well used by patients and relatives.

**Considerations**

- This strategy was inexpensive to set up, the main costs being coloured ink for printers and laminating pockets.
- Getting agreement from the monthly Falls Steering Group for the document has proved very time consuming.
- Caldicott approval was required for data collection.
- The project had to be registered with the Clinical Audit Team.
- Ethical approval was not required.

Electronic examples of flow charts, assessment documents, care plan falls log and information booklet are available on request.

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# *Life Long Living Project*

Established in April 2002, the ***Pennine Acute Hospitals NHS Trust*** is one of the largest in the country. It employs 10,000 multidisciplinary staff at five major hospital sites and provides a broad range of specialities and services to the people of Bury, North Manchester, Rochdale and Oldham.

**Aims**

The aim of the Life Long Living Project is to support the implementation of Standard 4 of the National Service Framework for Older People across the trust. It is anticipated that by investing in the education of staff at all levels, raised awareness of the issues facing older people during hospitalisation will result in an improved experience for older people.

**Project Approach**

Two Practice Educators have been appointed to deliver a training package consisting of a ten day multidisciplinary course, which covers:

- Ageism
- Mental health issues
- Fluid balance and nutrition
- Discharge planning
- Ethical and cultural activities
- Protection of vulnerable adults
- Medicines management
- Privacy and dignity
- End of life pathway
- Common Conditions

The course has RCN accreditation but is multidisciplinary in its suitability. The main eligibility criteria are that the candidates are providing services to older people during the course of their work.

Students maintain a reflective journal, which evidences the impact of each session on their working practice and is submitted at the end of the course to form 50% of the marking criteria. Additionally, a presentation at the end of the course detailing a particular aspect or incident in their work during which actions taken have been influenced by course participation and have led to improved experience for the service user, form the remaining 50% of the marking criteria.

The Practice Educators deliver the course at each site, supported by specialist speakers using evidence based and current information. A portion of funding is being used to 'back-fill' shifts in order to better facilitate release from duties and improve attendance. The students evaluate the course at the close of each training day and again at completion of the course. Sessions are checked and updated as each programme is rolled out. In addition to the formal training course, Practice Educators are able to attend individual areas and tailor training to the specific needs identified.

The natural progression of this work is to introduce a network of Link Champions for older people across the trust. Staff that have successfully completed the multidisciplinary training have been invited to participate in the network which is also being advertised across the trust. The aim is to recruit staff that are willing to work together and use their influence as Champions to improve older people's services and represent their interest across the trust. Two separate training days are planned, following which the Older Person's Champions Network will be formally launched to focus on improving the hospital experience for all older people.

**Conclusions**

The project continues to develop, addressing areas such as ageism and person centred care as well as raising the profile of the hospital experience for older people. The multidisciplinary training programme sows seeds of knowledge and awareness from which the Champions Network will rise and branch out to all areas of our service, sustaining the improvements and changes following the completion of the project.

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# Falls Prevention Coordinator Post in an Acute Hospital Trust

The standard 4 funding supported a number of schemes at the ***Poole Hospital NHS Trust***, including the provision of specialist equipment for older people and a review and overhaul of information available for older people and their carers. This abstract focuses on one aspect of our project: falls prevention. During 2004 there were a total of 1,935 falls recorded in the hospital, over 50% of these occurred on the six Care for the Elderly wards. The trust recognised the need to reduce the number of falls occurring in accordance with the NICE Guidelines[1] and the NSF for Older People. There was also a need to raise awareness of the impact of falls among staff, and a Falls Prevention Coordinator was appointed for one year to work towards this aim.

**Aims**

- To reduce the numbers of falls for hospital inpatients and to ensure the trust complies with national guidelines.
- To identify and provide the optimum safe environment for persistent fallers.
- To assess patients with a fall related diagnosis with regard to their fall in addition to their presenting complaint.
- To assess the fracture risk of older patients who fall.
- To identify people presenting in A&E with a fall related incident and provide appropriate follow-up to reduce the likelihood of re-attendance or re-admission.
- To streamline care between the hospital and primary care falls services.
- To raise awareness of falls among staff, patients and carers.
- To streamline existing work on falls within the hospital.

**Findings**

An audit of 60 patients aged over 65 and admitted to hospital after a fall was carried out. A retrospective review of medical notes was undertaken to establish what health care professionals did to investigate a patient's fall on admission and whether appropriate action was taken. Only 33% of the patients were asked about previous falls and 55% about the characteristics of their fall. None had been referred to the Specialist Falls Teams.

**Achievements**

- A Falls Prevention Protocol was piloted during a three month period on an acute medical/elderly ward. This used a simple format to highlight possible causes of a patient's fall and gave an action plan to follow. In the control group of 132 patients who were not using the protocol, 40% sustained a further fall. Of the 142 patients treated using the protocol, only 15.5% fell again.
- A database of repeated fallers has been created to inform community falls teams of all patients admitted who may need their expertise on discharge.
- Use of the Falls Prevention Protocol has resulted in a 50% reduction in falls in similar sized groups of patients. This is now being trialled throughout the hospital. A cohesive, effective strategy for care of patients admitted as a result of a fall, or who fall in hospital is in place and awareness regarding falls prevention is being raised.

By the end of 2005 it is anticipated that there will be:

- Effective use of the limited falls equipment according to risk for each patient.
- Raised awareness of what falls mean for the older person among staff, patients and carers.
- Fracture risk assessments and appropriate treatment for older people who fall.
- An effective network between the hospital and community falls services.
- An occupational therapy review for all A&E attendees over 75 admitted following a fall.

**Conclusions**

This important role allows for the creation and implementation of strategies likely to reduce falls in older people at risk. The Falls Prevention Coordinator chairs the existing hospital Fallers Group providing a greater focus on falls prevention throughout the hospital. Existing initiatives for reducing falls in the hospital are now being coordinated and made more effective.

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[1] NICE Clinical Guidelines 21. The assessment & prevention of falls in older people, November 2004.

# *Shape Attitudes, Influence Behaviour, Improve Care*

The ***Portsmouth Hospitals NHS Trust*** project focuses on participation and sustainability and is based on the concept of transformational and social learning theory. This is where change and transformation results from individuals developing self-awareness and understanding through reflective and group action learning set activity. This methodology was chosen to focus on sustained attitudinal and behavioural change.

**Aims**

To increase and enhance the knowledge and skills of staff and to challenge and influence their attitudes and behaviours.

**Project Approach**

Six pilot areas were recruited to the project, with 12 senior nursing staff (H–E grades) undertaking the development programme to become Older Persons Champions. This sample size enables focus whilst ensuring an adequate number of wards participating to test transferability/applicability. The programme participants have completed six months of development where creativity was emphasised by the use of forum theatre, use of older peoples' narratives, observation of care, action learning and the Critical Companionship model of facilitation.

The Older Persons Champions now act as facilitators for change. One aspect of improving care for the older person was identified by the champion following three assessments of care within their own clinical area. Work-based projects are supported by action learning groups for both the champions and the clinical areas.

Customer care training is also provided, using the NHSU teaching aid, and a training needs analysis has been undertaken. This provides the basis for the development of a multidisciplinary learning and development framework for the care of older people in an acute setting.

The importance of lasting commitment from those who shape the organisation at the highest levels has been recognised. A robust project management infrastructure has been developed via a Project Management Group and a Steering Group. These ensure clarity of accountability and effective communication. The groups comprise stakeholders from within and outside of the organisation including service users and voluntary agencies. A Non-executive Director, the Deputy Chair of the trust, Chairs the Steering Group, ensuring a high profile and direct reporting to the trust board.

**Achievements**

- Thirteen champions have successfully completed the development programme and evaluated the creative content positively.
- Work-based quality improvement projects commenced.
- Action learning groups developed with programme participants and ward staff.
- The Project Management Group and Steering Groups have provided effective support.
- The project is being undertaken as an action research project in collaboration with University of Portsmouth.
- The Healthcare Commission acknowledged the project in a recent joint inspection for the NSF for Older People as concern had been expressed in the past by older people of some staff members' negative attitudes.
- The Modernisation Agency posted the project on their website in April 2005.
- A publication has been accepted by the Nursing Times for August 2005.
- An older person's oral history of life caring for his wife with dementia has been recorded.

**Conclusions**

This project will complete in March 2006. To date, the greatest achievement has been to see individual champions attitudes change towards older people, and to see and hear how the champions are using what they have learnt to change behaviours in the clinical areas. Significant progress has also been made in developing relationships with other health and social care providers, ensuring sustainability on completion of the project.

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# Age Matters

The ***Royal Devon and Exeter NHS Foundation Trust*** project aims to improve the physical and mental healthcare experience of older people whilst they are inpatients. This will be achieved by developing strategies to ensure that older person's care is delivered through appropriate specialist care and by hospital staff with the right set of skills to meet needs.

**Aims**

- To improve the overall experience of older people throughout their hospital journey.
- To recognise and fully support carers within their identified roles.
- To identify gaps in staff knowledge and skills and develop education programmes at a local level to address these needs.
- To identify older people with mental health needs.

**Project Approach**

- A skills analysis questionnaire was sent to a 20% random sample of staff identified in key areas for education and improvement. The questionnaire's lowest scores were found in the following areas; the single assessment process; vulnerable adults; falls management; nutrition; management of incontinence; essence of care and podiatry.
- A patient satisfaction survey identified key themes relating to the length of time patients had to wait to be offered food or drink. Sensory deficits were also highlighted because some patients had difficulty in reading the print on the hospital menus or could not clearly see toilet signs.
- Information from PALS and common themes emerging from patient complaints identified communication as a common problem. This is being taken forward through "The essence of care communication bench mark" .
- Direct observation of practice by older person's nurses and patient narratives. Staff observed many patients had no footwear on arrival to hospital, a provision of 24 hour hot food was not available and spiritual needs were not always identified and met.

**Achievements**

- Increase in hospital staff's knowledge of older people's care.
- Improved risk assessment with regard to falls; this work will be sustained by ward staff for patients on admission.
- Improved awareness of vulnerable adults care.
- Increased understanding of the Single Assessment Process.
- Older peoples Champion Link Nurses established in ward areas. Education sessions undertaken so far on the project include; hearing aid maintenance; nutrition; essence of care; pressure sores; ophthalmology and confusion.
- Large print menus have been distributed to ward areas and a trial of toilet signs has been undertaken to support patients with visual problems.
- Falls assessment tool and pathway designed and piloted on ward areas and pre-assessment clinic. The falls assessment tool has been found to increase nurses' awareness of high-risk patients and improved nurses' ability to plan care.
- Older person's nurses are part of a working group to support the development and implementation of integrated care pathways.
- Trials have begun of the Single Assessment Process documentation in clinical areas.
- Design of a Vulnerable Adult Flowchart to be used within the Royal Devon and Exeter NHS Foundation Trust in conjunction with the Discharge Facilitator.
- A grant of £2500 has been obtained to undertake a podiatry research project with regard to falls pain and immobility. The research proposal was written by the older person's nurse and passed scientific review. The grant was awarded by the Research and Development Department within the trust.

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# Older People Skills Team

The ***Royal Liverpool and Broadgreen University Hospital NHS Trust*** Skills Team Project is to be implemented over a two year period and consists of a Project Manager, two F Grade Sisters and a Level 3 Health Care Assistant.

**Aims**

- To make sustainable changes to the care that older people receive within the trust and improve access and advice from specialist services.

**Project Approach**

The team spend three weeks in each ward area across the trust. During this time they:

- Audit the present standards of care for older people.
- Implement ward based learning.
- Mentor each nurse by working with them and providing feedback.
- Ensure that evidence based practise is embedded in clinical practice.
- Provide education packs as a resource for newly qualified staff, student nurses and agency staff.

Base line data is collected by:

- A nursing skills audit.
- Observations of care.
- Reviewing complaints/ patient stories.
- Review of progress with Essence of Care and Professional Development Plans.

Each ward area, in conjunction with the Matrons, develops an Action Plan for Improvement, which is reviewed regularly. This is supported by facilitation of Action Learning Sets. The team will revisit each ward area towards the end of the project and re-audit to establish whether sustainable improvements have been made.

**Achievements**

- The team have worked in 29 ward areas to date and mentored approximately 400 staff.
- In line with Standard 4, the Nursing Skills audit and Observations of Care, key areas for intervention have been developed during the mentoring process.
- An audit tool to review patient care, with a standard for each intervention, has been developed. Indicators and criteria have been devised from the results. This comprehensive audit is completed for each patient over 50 years of age and draws information from three areas; patient's response; observations of care and documentation.
- The results of the audit have influenced a review of nursing establishments and documentation.
- The project is supported by the trust's Executive Board, Divisional Nurses and Directorate Managers.
- Through Action Learning sets, directorate action plans have been developed to improve patient care.
- The team have gained acceptance as part of the multidisciplinary team within the ward areas.
- The team have raised the profile of care for older people within the trust and work closely with the Older Peoples Champions Network.
- The education pack is to be CPD accredited.
- Mentoring proformas have identified areas of development for personal development plans.

**Conclusions**

The project has attracted much attention from outside the trust, especially in terms of the Older People Skills Audit Tool. The standards and audit criteria developed are proving to be an excellent tool for evaluating and assessing the care of Older People on acute care wards.

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# High Quality Care for the Older Person: a Hospital-wide Approach

The ***Royal Surrey County Hospital NHS Trust*** project started in July 2004, followed by a workshop event in September 2004. Attendees included carers, users, and community and hospital staff. In addition to this work, the Trust Chief Executive engaged an external Organisational Development Consultant. There are clear links with transforming hospital care for older people and the organisational development work (keeping in touch with our patients' stories helps us all develop a clearer Patient Line of Sight) and the Project Manager is involved in both.

**Aims**

- To establish high quality and equal standards of care for all older patients wherever they are in the hospital.
- To establish equity of access to services.
- To ensure sustainability of standards through the development of competencies and education programmes for a wide range of staff.
- To value the contribution of patients and the public throughout the project.

**Project Approach**

- *Surrey 50+ Network* - The Surrey 50+ Network, run by Surrey County Council, exists to engage people over 50 in decision making. 46 network members expressed an interest in four work areas; communication; environment; training; and telling their story. Two workshops were held for each of the topic areas in local centres. A one day workshop was also held July 2005 and was attended by members of the hospital staff and the Patient Forum.
- *Patient Line of Sight* - The Project Manager worked on the wards, where she acted as a change agent for two care of the elderly wards and two orthopaedic wards. Patient stories were collected and shared with the core teams. These teams were chosen by the sisters and usually consisted of the housekeeper, a consultant, a therapist and a Nurse. Listening to the stories allowed the core teams to design change agendas.
- *Knowledge and skills* - The training needs were identified by staff and suggestions from the 50+ workshops.
- *Environment* - Mystery shoppers from the Surrey 50+ Network have visited the hospital to find their way around the hospital, from the main road to the ward toilet and have also looked at our information for visitors.
- *Access* - An audit proforma was devised to assess patients aged over 75 years, who were not admitted by the care of the elderly consultants. The audit has been undertaken with their input. The Royal College of Physicians National audit on continence care for people aged over 65 years has also been completed.

**Achievements**

- *Patient Line of Sight* - Changing visiting times to provide 'protected patient time' in the afternoons during which nursing staff; provide foot and nail care; actively orchestrate and facilitate ward rounds; review team working; review the vision and purpose of the ward / unit; work with general managers on realising that vision; and work on patient guides and visitor information.
- *Dementia* - A one day workshop was commissioned and facilitated by an Independent Nurse Consultant in dementia care and four afternoon sessions based on the wards followed. The Orthopaedic Unit is having a rest time for patients and devising a leaflet to help explain to patients the behaviour of people with dementia.
- *Hospital Induction* - This has been changed to include good communication with patients and awareness of sensory disabilities.

**Future Goals**

- Surrey 50+ members are working with hospital Matrons to devise coding so that staff will know that a person has a hearing impairment and thus ensures the person has their hearing aid.
- Volunteers from the local Alzheimer's Society to act as a resource for ward staff. Ongoing dementia sessions are planned e.g. with phlebotomists.
- Further work on Patient Line of Sight and improvements in both hospital-wide and local inductions.

**Conclusions**

The project has raised the profile of older people's needs to the senior management team. As a result of the Surrey 50+ workshops, the Patient and Public Involvement Strategy is being revised to include a wider audience and a workshop approach.

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# Wising Up!

***Salford Royal Hospitals NHS Trust*** is a 980 bed teaching trust which has made good progress in achieving the targets set within the NSF for Older People, along with its partners in Salford's Older Peoples Development Board (OPDB). The "Wising Up!" project was seen as an opportunity to build on achievements within the hospital and produce sustainable improvements. The project is actively supported by the OPDB.

**Aims**

- To act as a catalyst to facilitate a culture change within all levels of the organisation by building on existing proven structures and good practice, leading to a better experience for older people throughout the trust.
- To embed the key principles of Standard 4 of the NSF for Older People within the organisational framework of the trust.

**Project Approach**

The "Wising Up!" Steering Group identified the following key themes for sustainable development:

- Designing an effective communication strategy e.g. The "Wising Up!" website.
- Linking with other key agendas such as Essence of Care and Privacy and Dignity policies.
- Developing links with key staff groups at all levels throughout the trust.
- Setting up a Champions Network.
- Identifying existing training and development opportunities e.g. working with the Learning and Development Directorate.
- Working with users and carers by identifying User Champions from other established user groups.
- Identifying priority areas for action planning with specialties and staff across the trust such as A&E and surgical specialties.
- Establishing a support network for older people's services.

**Achievements**

- We now have an evolving network of champions at grass roots, managerial, user and clinical levels within specialities and across the trust.
- Ongoing work with other directorates in analysing and enhancing their work with older people with the help of a checklist. e.g. intestinal failure and A&E.
- Surgical specialties identified a need to develop the role of an Assistant Practitioner with enhanced knowledge and skills required to care for older people. The "Wising Up!" project helped develop and fund this role.
- Established links with the Learning and Development Team to promote an older person focus in existing training activities and to further embed the core skills identified in the Knowledge and Skills Frameworks.
- Identification of key themes for action relating to older people's care across the trust. For example working with the Mental Health Trust to evolve programmes designed to improve the skills of acute trust staff working with older patients with mental health problems and vice versa.
- A website for the "Wising Up!" project has been set up on the hospital intranet, with a dedicated page for champions.

**Conclusions**

The most important consequence so far has been raising awareness at all levels within the organisation that getting it right for older people would ensure getting it right for all. "Wising Up!" is working with individuals and teams across the trust to identify and develop opportunities presented by existing strong foundations and good practice to achieve positive benefits that can last beyond the life of the project.

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# Service Needs of Older Patients Admitted to A&E

***South Devon Health Care NHS Trust*** provides the acute hospital setting in which this project has been based. The South Devon area has an increasing number of older patients and is an area that requires development of service provision.

### Aims

- To improve the services provided to older patients admitted to the trust as an emergency admission.
- To establish how the patient journey could be enhanced through improvements to assessment and referral processes at the earliest point of their attendance in the Emergency Department.

### Project Approach

The project was led by a Nurse Practitioner in medicine and has been supported by colleagues within the speciality of Older Person's Care and the Directorate of Emergency Services.

The Nurse Practitioner was primarily based within the Emergency Department (including the Admissions Unit), and worked closely on a daily basis with the Emergency Admissions Coordinator, Specialist Nurses and allied health professionals.

Clinical practice incorporated patient assessments, referrals to health care colleagues, patient processes, data reviews, and clinical audit.

### Achievements

- Establishment of a physiotherapy service input for elderly medical patients within the Emergency Department.
- Successful three month trial of occupational therapy service input for older patients within the Emergency Department. This now requires validating following the collation of audit data.
- Design and implementation of a radiology protocol to allow for nurse requested chest X-rays, so expediting the assessment and diagnostic process.
- An audit of patients admitted through the Emergency Department with a urinary tract infection as their primary reason for admission, has highlighted care needs and possible alternatives to admission.
- Improved network of clinical practice and referral with relation to the Clinical Nurse Specialists (dementia, stroke, Parkinson's, Outreach) has been established.
- A more proactive approach to the management planning of confused older patients.

### Conclusions

The main outcome of our project has been the opportunity to evaluate and implement a process of care for older patients, which has a multidisciplinary team approach and facilitates interventions at the earliest point during a patients hospital stay.

Accessing patients within the Emergency Department (including the Admissions Unit) during their first 24 hours after admission has enabled patients to be seen and assessed earlier by Specialist Nurses, Physiotherapists and Occupational Therapists.

This has expedited the patient care process, enabled journey mapping to take place earlier and prompted consideration for alternatives to admission.

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# The Road to Success: Older Persons Outreach & Support Team

The Older Persons Outreach and Support Team (OPOST) is a multidisciplinary, multi-agency team working at ***Southampton University Hospitals NHS Trust.*** The team's focus is on improving the care of older people who are in hospital through the three key methods of promoting best practice, education and influencing service development. The team has been operational since July 2004 and during this time has achieved some real successes, all of which have had a clear impact on the service provided to patients.

**Promoting Best Practice**

OPOST uses the Essence of Care clinical benchmarks as the foundation for their risk assessment and management of the complex needs of older people who are in hospital. The impact of these interventions has been measured in terms of:

- Numbers of admissions prevented: *approximately 15 - 20 per week.*
- Percentage of patients successfully discharged (i.e. NOT re-admitted within 7 days for the same problem) *99%*
- Reduction of length of stay: *average one day.*

Promoting best practice relies on teamwork and good relationships. A staff satisfaction survey of OPOST's performance showed 95% were very satisfied (those less than satisfied stated that this was because they felt OPOST should be available out of hours and more widely).

**Education**

OPOST is committed to improving the knowledge and skills of staff in order to improve the care of older people. In order to do this they have been able to provide a range of teaching and learning opportunities for staff. This has included:

- Regular staff updates on A&E induction programmes on services available for older people.
- Ward-based teaching sessions.
- Arranging master class workshops e.g. footcare for older people.
- One to one coaching on the wards using a case study approach.
- Developing 'Top Tips' cards to encourage timely referrals and support discharge planning.
- Linking with Older Person's Mental Health Services (OPMH) and the Alzheimer's Society to raise awareness about the needs of inpatients who have dementia.
- Providing a placement for students on nursing, foundation degree and new generation undergraduate programmes.

**Influencing Service Development**

OPOST has participated in the development of Rapid Response Services, highlighting the most effective interfaces for primary and secondary care. OPOST is also contributing to the development of the OPMH Liaison Service for the acute trust and takes the lead for the implementation of adult protection in the Emergency Department.

**Future Aspirations**

A business plan is being developed for the 2005/06 Local Delivery Plan processes to secure future funding for OPOST. The financial benefits are clear: admissions prevented, readmissions avoided and saved bed days. The more qualitative improvements can be measured in terms of staff and patient satisfaction.

By supporting the ongoing work of OPOST, the local health economy will enable staff to work towards achieving the following goals:

- All older people who are admitted into the acute hospital will have access to a multidisciplinary assessment based on the Essence of Care clinical benchmarks.
- All older people, who meet the OPOST referral criteria, will have access to the team.
- OPOST will continue to expand their education programme to include e-learning and multimedia (use of CD-rom and video).

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# National Service Framework – Standard 4

The ***University College London Hospitals NHS Foundation Trust*** project commenced in November 2004. At present a Nurse Facilitator within the Medical Directorate is working full time on the project. The Modern Matron for Medicine is overseeing the project but this role will soon be transferred to a recently recruited Nurse Consultant.

**Aims**

- To support implementation of the NSF for Older People throughout the trust, though in the first year the focus has been to ensure that the NSF can be taken forward in the new University College Hospital site which opened in spring 2005.
- To raise awareness of the NSF whilst supporting staff in achieving the milestones.

**Project Approach**

- A priority of the project has seen the recommencement of the NSF working group which had disbanded in 2003. Meetings are now taking place every two months with updates on progress within the NSF discussed and cascaded throughout the trust as a result.
- A training needs analysis has been commenced in the Medical Directorate and will be cascaded throughout University College Hospital once all areas have moved and settled into the new site. An assessment tool has been developed as a direct result of the project and all analysis of data return is being undertaken by the Nurse Facilitator.
- Training and Education programmes encouraging a multidisciplinary approach are led by the Practice Development Team with close working links with the Nurse Facilitator for the project. Results of the training needs analysis will be fed back to the Team to allow adaptation of training days, the adaptation of training will be in direct response to the needs analysis.
- The Nurse Facilitator and the Trust Dementia Nurse will be investigating and producing an assessment tool and care pathway for the confused older person and the work plan for this is currently under discussion.

**Achievements**

- A Falls Information booklet has been produced by the Modern Matron for Medicine and the Reach Team Physiotherapist. The booklet gives local contact numbers and community initiatives within the three local PCTs. The booklet was launched on Falls Awareness Day.
- A Dignity on the Ward audit has been undertaken by the Nurse Facilitator within the Medical Directorate. The focus of the audit has been on:
  - patient environment
  - privacy, dignity and modesty,
  - communication,
  - promotion of individual needs and
  - staff training.
- There is to be a second audit following the move into the new hospital site to see the impact of the environmental changes for patients, carers and trust staff as a result of the move.

**Conclusions**

The first nine months of the project have received extremely feedback and it is hoped that the second phase, with the introduction of the Nurse Consultant, will bring very exciting results and move the trust progress within Standard 4, alongside the other seven standards, markedly forward in developing older peoples' services at UCLH and the surrounding Primary Care Trusts.

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# Does a Dedicated Team Facilitate Change?

The ***University Hospital of North Staffordshire NHS Trust*** (UHNS) appointed a project manager to facilitate progress against standard 4 of the NSF for Older People. From the outset, it was recognised that without support and integration into the trust's existing management systems, impact would be limited in such a large organisation. It was crucial, therefore, to link the Project Manager's work around standard 4, with that of the Service Improvement Team and to mainstream it within Divisional structures. Access to the Medical Director, the Professional Heads of Nursing and other Divisional Leads was instrumental in getting the assistance at the right level to ensure the work for standard 4 is embedded as a fundamental philosophy within the trust. In order to mainstream suggestions made from the findings, it was necessary to form early connections with training and education, both within the trust and with the local Universities. Strong links have been formed with the Modern Matrons, Medical Education Coordinators, the trust's Training and Education Coordinator and Staffordshire and Keele Universities.

**Project Approach**

The project was divided into two distinctive elements. The initial twelve months were used to undertake a skills profile audit to identify gaps in existing skills and knowledge around care for older people, for all staff working in the trust that have contact with older people. The second year would be used to establish ways of addressing these gaps and linking them into mainstream practice.

To complete the skills profile identified in standard 4, a triangulated approach of questionnaire, semi-structured interviews and delivered questionnaires was adopted in order to produce a comprehensive analysis of the training requirements for all staff groups across the trust. The questionnaire was devised to assess the level of skills and knowledge of staff in all the key areas. Following a consultation period for content, Clinical Audit were involved for design ideas. The questionnaire was piloted with a cross section of staff from different professions and shared with the Matrons, the trust's NSF Steering Group and a group organised by Age Concern, to capture the older person's perspective. These comments and the result of the pilot study were incorporated into the final draft.

As not all the questions were applicable to all staff groups, versions of the questionnaire were derived from the complete draft, using comments from the pilot study. In total, 3473 questionnaires were distributed and 753 were returned, providing a 21.7% return rate.

**Achievements**

- Results have shown that physical and psychological needs of older people have been identified as areas staff would like more training in, in order to provide a better level of care for older people.
- The results are in the process of being further analysed to identify training needs specific to each profession. This will eventually be split down into training needs by profession in each division (data reliant). By doing this it aims to provide each division with an idea of which areas they need to address in their Divisional Learning Plans.

**Future Goals**

- The results will also be used to highlight training needs to be addressed in the trust Learning Plan. To reach new staff to the trust, negotiation is underway to incorporate a section in the trust Induction Programme.
- Links made with the local Universities may prove invaluable as, based on preliminary results, a recommendation will be made to attach a core module to all health related undergraduate and postgraduate courses.

**Conclusions**

Getting the NSF for Older People on the agenda of a trust is difficult but undeniably essential. Raising the awareness of the individual standards presents its own challenges in a large organisation and this is true of standard 4 of the NSF. The approach outlined above aims to:

- Minimise the effect of the change.
- Ensure the sustainability of the changes required by the NSF, by placing them in mainstream practice.
- Place the changes within a system to provide drive, performance management and focus.

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# Older Peoples Education and Practice Development Team

A team of five at the ***University Hospitals of Leicester NHS Trust*** provide practical educational and development opportunities for both clinical and non-clinical staff, across the three sites of one of the largest acute trusts in England. A skills survey carried out in the autumn of 2004 asked staff to rate their skills, knowledge and competency in 15 areas taken from standard 4 of the NSF for Older People. The results have become the priorities of the team to target in practice.

**Aims**

- *To use feedback from older people to improve their experience of hospital care.*

We use patient's feedback to directly influence the care of the older person across the trust.

- *To provide educational programmes to meet the needs of staff caring for the older person.*

We are able to reach targeted audiences enabling them to significantly influence the attitudes and care of the older person. The team are working in partnership with hospital, community and voluntary sector services to maximise multi-agency participation to improve older peoples care.

- *To directly impact on the standards of care the older patient receives in hospital.*

We work with clinical areas to help implement sustainable changes that are directly focused on improving the care of the older person in hospital. The team revisit these areas to ensure changes continue to make an impact and they offer ongoing support. The team are ensuring healthcare staff and their training teams have access to high quality training materials relating to older peoples needs.

- *To celebrate the teams achievements and share best practice.*

We have a strategy to ensure the wider health and social care community are benefiting from their experience and achievements. The team plan to hold seminars for training teams and conferences to share good practice using the clinical teams they have worked with themselves to present their successes.

**There are two key components to the team's role:**

- *Corporate Role* - Incorporating older people's perspectives into established corporate training materials and highlighting the reality of older peoples care experiences. We work in partnership with teams such as the infection control service to achieve this. The training takes place once a week on all three trust sites and incorporates a mix of outside speakers and a variety of educational material suited to all staff groups. The topics are delivered in line with the outcome of the staff skills survey. The team also supports the trustwide Older People's Champion Network.

- *Clinical Role* - Working directly with staff in wards and departments and assisting areas to lead positive service change. Audits are undertaken prior to a practical ten-week placement, then working in partnership with the ward teams, change programmes are designed to directly improve the care and experiences of older people. Staff skills are improved by one to one training as well as personalised local training packages. The teams experience in older peoples care allows them to function as role models and experts to support the clinical teams they are working with.

**Achievements**

- A quarterly newsletter for staff that has been a huge success in spreading the word and sharing best practice.
- The 'Voices of Older People' video, made in partnership with Age Concern, allows staff in clinical areas to hear the concerns of older people about general hospital care.
- CD training resources are being developed for use in hospital and other community settings allowing the material resourced and developed to be used to educate future staff.

**Future Goals**

The development and production of 'products' is seen as a key way to ensure the sustained impact of the project. The challenge is to significantly change attitudes and perceptions of staff and influence the care of older people in the future. Ongoing evaluation of this project and its outputs are vital to ensure that the older people's experience is improved and sustainability of our work is a major factor in a time limited (funded) project.

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# *Promoting Patient Independence and Well Being*

Older adults are particularly vulnerable to problems which can arise during a hospital stay[1]. They are at high risk of poor functional outcomes because they are "less likely to recover activities of daily living and more likely to develop new functional deficits during hospitalisation" [2]. This highlights the need to make changes in the provision of acute hospital care for older adults, with the need for preventative and rehabilitative interventions. This project aimed to evaluate an education programme for Health Care Assistants and nursing staff working with older adults on one acute ward at ***West Middlesex University Hospital NHS Trust.***

**Aims**

The project aims to equip the Health Care Assistants with the necessary skills to carry out rehabilitation programmes with patients seven days a week.

***Patient Objectives***

- To improve user care experience
- To improve functional ability at discharge
- To reduce length of stay
- To reduce discharge care package and complexity

***Staff Objectives***

- To improve staff rehabilitation skill base
- To increase staff involvement in rehabilitation
- To increase job satisfaction
- To increase inter-professional working

**Project Approach**

Before an education programme could be carried out, data on existing practice was collected through staff and patient interviews, staff observations and a documentation audit. Following the initial data collection and analysis, multidisciplinary workshops were held to address issues that were raised. Portfolios were used with the Health Care Assistants to develop their skills to promote older peoples independence by setting individual learning objectives. The same data collection methods were used at the end of the study. Ethical approval was gained from the Hounslow and Hillingdon Research Ethics Committee.

**Achievements**

- *Patient Outcomes* - After observing the Health Care Assistants carrying out morning care, more time is now spent allowing patients to participate in an activity (rather than doing it for them) which promotes feelings of independence.
- *Staff Outcomes* - Results from the staff interviews showed there was an increased awareness by the multidisciplinary team of the role nursing staff, and particularly Health Care Assistants, play in rehabilitation. There has also been an improvement in knowledge and skills of the healthcare assistants in promoting older adults independence in hospital.

**Conclusion**

Wider implementation of a rehabilitation philosophy in the acute setting is recommended. Through promoting the independence of older adults they are less likely to deteriorate during their hospital stay and more likely to be discharged earlier. With nursing staff skilled to promote independence throughout the week, low level rehabilitation needs can be addressed outside of therapy services, freeing their capacity to allow them to focus on older adults with more complex needs.

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[1] Department of Health (2001) National Service Framework for Older People. Stationary Office. London
[2] Covinsky KE et al (2003) Loss of Independence in Activities of Daily Living in Older Adults Hospitalised with medical illnesses: Increased vulnerability with age. JAMA 51(4) 451-458

# *Working Together: Holistic Care for the Older Person*

The ***Worcestershire Acute Hospitals NHS Trust*** began the 'Working Together' project, employing two Practice Facilitators to work alongside staff, assessing current practice and highlighting areas of concern. From their findings they have disseminated data to the executive team as well as the individual clinical teams.

**Aims**

To ensure that all older people attending the trust gain maximum benefit from their stay in hospital and receive the specialist care they require.

**Achievements**

❖ *Assessing clinical areas* - The Practice Facilitators are working alongside staff in a supportive role, encouraging them to share ideas about clinical practice and caring for the older person. During this time we have assessed twelve clinical areas against Standard 4 of the NSF for Older People. Each area has been left with a report that highlights good practice, for example:

- The establishment of a Rapid Response Service based in the A&E department.
- Ward-based achievements such as the Trust Medicine Management Scheme. This involves a pharmacist taking full responsibility for ordering and monitoring medications as well as giving advice and information to individual patients and their carers.

The reports also contain recommendations on which areas need improvement and the ward sisters are asked to transfer these into an action plan. We then review its implementation on a quarterly basis.

❖ *Champions* - The Practice Facilitators have trained over 50 champions for older people in all clinical areas. They have been able to explore and heighten awareness of the individual needs of the older person, as well as sharing best practice. A variety of teaching skills such as reflective practice, experiential learning and critical analysis are being used to promote a "no blame" culture which is both motivating and empowering. The champions attend an interactive study day which addresses topics such as the ageing process, Standard 4 of the NSF and Essence of Care. Each clinical area then identifies quality initiatives that they wish to work on. Examples include:

- Improving continence care.
- Developing a resource file containing specific contact details and information to aid the discharge planning process for the older person.
- Developing person-centred goal setting in the multidisciplinary meetings.

Other achievements:

- ❖ The Practice Facilitators are involved in the development of new training programmes both internally and at Worcester University, offering advice and expertise on all aspects of the NSF for Older People.
- ❖ With a new lead for the project in post, we are now able to influence change further by developing and reviewing policies, such as a Privacy and Dignity and a cot side policy.
- ❖ Through clinical assessments against Standard 4 of the NSF, the need for a Continence and Nutritional Specialist Nurse is evident, as well as an urgent need to unify documentation within the trust. These issues are now been addressed at a corporate level.

**Conclusion**

Management of change is always difficult and cross trust working has been one of our main problems. Encouraging staff to attend the monthly focus groups, so that they can discuss their individual projects and share their progress has been difficult and we are currently reviewing this process.

The 'Working Together' project continues to develop and is regularly evaluated. It is both fluid and dynamic in nature and because of this we have been forced to continually adapt our responses to the changes. This in turn has had a huge impact on our own professional development. Ultimately we are determined to make a difference to ensure that older people get the best possible care and gain maximum benefit from their stay whilst in our trust.

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