Borders NHS Board

CARE OF OLDER PEOPLE IN HOSPITALS (FORMERLY OPAH) UPDATE

Aim

To assure the Board that planned activity relating to the Care of Older People in Hospitals standards is being monitored and delivered across the sixteen standards with an improvement focus and that this is evident throughout NHS Borders.

Background

Healthcare Improvement Scotland (HIS) Care of Older People in Hospital (COPH) standards (2015) set the minimum standard that older patients should expect as a baseline when an in-patient in our care. From the admission to discharge planning and to preparing support when they leave hospital the sixteen standards address many of the fundamentals of our practice.

The original Older People in Acute Hospital Care standards were published in 2002 and NHS Borders was inspected against those standards in 2012 and 2016 and the OPAH group was originally tasked with responding to the 2012 inspection and then the 2016 inspection.

The standards were updated in 2015 and any future Care of Older People in Hospital inspection from HIS will be against these and is likely to incorporate the Food, Fluid and Nutritional Care standards (2014) – which formed the basis of the inspection of the Borders General Hospital in 2017 – and the Prevention and Management of Pressure Ulcers standards (2016).

The OPAH group continues to provide oversight and assurance of the updated COPH (2015) standards working with key clinicians, managers and leaders to review the specific standards and to identify and support areas of strength and areas for development. The attached summary sets out our position against the COPH standards gives a fuller picture of work on-going and work completed across NHS Borders.

Although much of it has been scrutinised through the OPAH group, with the focus of HIS last inspection being on Food, Fluid and Nutrition and a substantial amount of Quality Improvement work being monitored and delivered through the Back to Basics - Forward to Excellence programme the reporting structure of the OPAH group has become opaque and requires reconsidering. The group itself would propose a subject specific update is presented to the Clinical Governance Group at each bi-monthly meeting.

Summary

Through the OPAH group, with the collaboration of service leaders across NHS Borders the attached summary provides a picture of our current performance against the standards

with identified areas of strength or completion and areas where work is in development or incomplete.

Areas of good practice:

- Fortnightly ward inspections against a range of areas of practice and COPH standards.
- Embedding of Person Centred Coaching Tool (PCCT) across BGH and community hospitals with SCN's reviewing five sets of notes weekly with their staff.
- 89% of patients receiving Comprehensive Geriatric Assessment within 72 hours of Hip Fracture against a national average of 82%
- On ward pharmacists fully engaged with medicine reconciliation for new admissions and having documented discussions with patients and families to support safe administration of medication.
- The Back2Basics programme is emphasising and delivering improvement through a Quality Improvement approach.
- The Back2Basics programme has provided a focus for improvement work aimed at reducing falls with harm.
- The H2H (Hospital to home) project is showing promising results at supporting people to regain independence in their own home.

Areas for Improvement:

- Care planning remains an area for development. The new Adult Unitary Patient Record builds care planning into documentation. This will continue to be monitored through the PCCT.
- The PCCT is not yet in use in mental health wards – The tool is having minor adaptations to be tested for use from September.
- There is no End of Life Care pathway to facilitate rapid discharges from hospital supporting people who wish to die at home. The project to bring this to fruition is underway.
- We do not routinely record who a patient permits to support them in decisions about their care. The next iteration of the AUPR will require this to be recorded.
- The ward environments through most of the BGH and our community hospitals are not delirium or dementia friendly. Inconsistent lighting, high levels of noise and few orientation points all pose problems for people with cognitive deficits – a project to begin to address this was unable to be supported.
- The Mental Welfare Commission for Scotland carried out a themed inspection across community hospitals in Scotland including the Borders identifying a range of areas for improvement. An Action Plan to address these is at an advanced stage of development.

Assessment

The 2015 standards are an evolution of the 2002 standards, not a revolution, and our preparedness for inspection against those is informed by previous experience.

Historically our relationship with HIS inspectors has been based around "inspection" and "response to inspection", predominantly we have been reactive. Over the past year there has been a deeper commitment in NHS Borders to using Quality Improvement

methodology in part in response to previous inspections and led through Clinical Governance.

In December 2017 we invited our link inspector, Irene Robertson, and a colleague to spend time in the BGH where we demonstrated improvement work being delivered much of it using Quality Improvement which was well received. In May this year Irene was invited to address our nursing conference on Inspection Methodology.

HIS are also providing support through their Quality Assurance arm with a second planned visit in September to demonstrate and discuss progress.

It is the view of the OPAH group that NHS Borders is in an improving position should we find ourselves hosting an HIS inspection against the COPH standards, but there is no reason for complacency. This is being delivered in response to inspection, by maintaining scrutiny and by incorporating Quality Improvement methodology where we are delivering change.

Recommendation

The Board is asked to **note** the update on progress to date.

Policy/Strategy Implications	To provide assurance of ongoing focus to achieve and maintain the COPH Standards outlined by Health Improvement Scotland and assure the Board of the quality of patient care.
Consultation	Consultation will be achieved through involvement in sub groups as well as through cascade within Clinical Directorate structures.
Consultation with Professional Committees	Senior Nurse and AHP groups, Borders Area Nursing and Midwifery Advisory Committee and Partnership will be involved in work as it is progressed.
Risk Assessment	The OPAH Oversight Group will develop a risk register which will be informed by sub groups. Comments and Complaints in relation to specific subjects e.g. Falls or discharge planning to ensure actions are followed through and learning is shared.
Compliance with Board Policy requirements on Equality and Diversity	Compliant.
Resource/Staffing Implications	There is an existing resource for some of the work within the Clinical Governance and Improvement teams. Other resource is from within existing contractual roles and responsibilities.

Approved by

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Standard 1: Involving older people: "What and who matters to me"		
Older people in hospital have the opportunity and are enabled to discuss their needs and preferences, including the people they wish to be involved in their care.		
Criteria	Areas of Strength	Areas in Development
1.1: Throughout their journey, older people in hospital have the opportunity: a) to say what and who matters to them b) are supported to ensure this is achieved, and c) have this regularly reviewed. 1.2: Older people in hospital are assessed to ensure their communication and sensory needs are met. 1.3: The patient's representative is involved where the patient has difficulties in communicating what and who matters to them. 1.4: Information about what and who matters to the patient is used in all care and treatment plans, provides the basis for shared decision-making, and: a) informs the setting and reviewing of personal goals and outcomes b) is regularly reviewed by the multidisciplinary team, and c) informs handovers, care transitions and discharge planning.	• New (in advanced testing) Adult Unitary Patient Record (AUPR) seeks to establish "Patient and carer expectations" & "What matters to me." • Asks for existing Getting To Know Me on admission.  260618- Adult ADMISSION Record \ • AUPR includes communication deficits and aids in assessment and incorporates carers views • Service Fundamentals of Care Audit Tool monitors: ○ how patients are being spoken to ○ how they are supported ○ how they feel ○ Are they included in decisions about their care.  HEI - COPH Assurance tool versio • Getting To Know Me is completed for all people diagnosed with dementia through MHOAS as part of Post Diagnostic Support. • Getting To Know Me offered to family members to complete with patients in in hospital where cognitively impaired. • Hospitals have open and accessible visiting arrangements. • Rehabilitation plans are patient centered and for safe and effective care - "What Matters to Me". • In Community Hospitals, following on from MDT, the patient and/or carer is informed of the meeting outcomes and engaged in discussion of rehabilitation goals, care plan and discharge plans. • NHS Borders has a translation services webpage. http://intranet/microsites/index.asp?siteid=92&uid=39 • NHS Borders has a webpage devoted to leaflets available in different languages and a link to wider services through NHS Scotland.	• AUPR has been tested in Medical areas. Requires further testing in surgical units before complete roll out. • New AUPR does not currently record who the patient has consented to have involved in discussions about their care. • Getting To Know Me is intended to be brought with patient when admitted to hospital. We can not currently evidence how often this happens. • Dementia Nurse Consultant has been tasked with evaluating the above.

	http://intranet/microsites/index.asp?siteid=92&uid=41 • Feedback from Fundamentals of Care audit. 230518 - Inspection.doc	

Standard 2: Maintaining patient dignity and privacy		
Older people in hospital will be treated with dignity and privacy, particularly during communication, physical examination and activities of daily living.		
Criteria	Areas of Strength	Areas in Development

2.1 A patient's preferences around dignity and privacy during sensitive conversations and activities of their daily living are sought, documented, actioned and shared with the multidisciplinary team, as required.
 	
2.2 Staff are competent in providing and supporting effective communication, and demonstrate a dignified person-centred approach.
	• As cited in Standard 1 the service Fundamentals of Care Audit Tool monitors:
	  ○ Do patients feel they have been treated with dignity.
	  ○ Is this supported by observation of practice?
	  ○ Is this supported by what is heard?
	• NHS Borders Complaints Handling Procedure reflects NHS Borders' commitment to welcoming all forms of feedback, including complaints. http://intranet/resource.asp?uid=31213
	• NHS Borders welcomes feedback through Care Opinion.
	• Where required people with dementia/learning disability coming in to hospital for planned admission (e.g. Surgery/Day Case surgery) adaptions are made as required for person-centred approach.
	• NHS Borders has in-place a Chaperone Policy.
	• http://intranet/resource.asp?uid=32124
	• Wards are considerate in prioritizing single rooms for end of life care.
	• The communication workstream in Back To Basics – Forward to Excellence programme is focusing on the importance of making people feel welcome.
	• Communication all day learning session with 14 staff to develop work on communication in their own clinical areas.
	• Three sessions run by external facillitator with all grades of staff around "Candour, Complaints and Conflict"
	• SCNs supported in professional development and improvement framework through programme developed with Queen Margaret University and NHES.
		• The environment within the BGH Wards has limitations for rehabilitation. Sited on the first floor of the hospital, a 6 bedded bay only allows for an individual bed and chair space. No social or dining space available and the ward siting reduces the access to outdoors and mobility.
		• There is one toilet and/or shower in the bay, so patient's personal care activities are regularly carried out at their bedside.
		• Wards private sitting areas are limited which does not always support dignity and privacy during sensitive conversations.
		• Back to Basics Communication workstream starting to test impact of small tests of change in communication on patient experience.

Standard 3: Decision-making, consent and capacity		
Older people in hospital are involved in decisions about their care and treatment.		
Criteria	Areas of Strength	Areas in Development
3.1 Patients will not be excluded from services, treatment or care on the basis of age. 3.2 Patients will not be excluded from services, treatment or care on the grounds of cognitive impairment. 3.3 Patients (and/or representatives) are involved in all discussions and decision-making relating to their care and treatment, and healthcare records clearly document: a) who the patient has consented to being involved in discussions and decision-making b) who has been involved in the decision-making process c) what information has been provided to the patient (and/or representative) d) the treatment options and alternatives available to the patient, and e) the patient's decision. 3.4 The patient's capacity for decision-making relating to their care and treatment, is assessed, regularly reviewed and documented, where clinically indicated. 3.5 For patients assessed as not having capacity to make decisions, the principles of the Adults with Incapacity (Scotland) Act 2000 are applied as follows: a) patients are supported to express their opinion and make a decision as much as they are able to b) proxy decision-makers (for example, welfare attorneys) are consulted regarding the patient's proposed care and treatment, and	• Ready access to Consultants in Geriatric Medicine ensure no patients are excluded from services, treatment or care on the basis of age or cognitive impairment. • Patient's capacity for decision-making relating to their care and treatment is assessed, regularly reviewed and documented.(AWIA) S47 forms are regularly reviewed and updated or discontinued appropriately. • Patients (and/or representatives) involvement in discussions and decision-making relating to care and treatment is currently recorded in the narrative of patients daily records. • Patients assessed as not having capacity to make decisions are supported to express their opinion and make a decision as much as they are able to. • Proxy decision-makers (for example, welfare attorneys) are consulted regarding the patient's proposed care and treatment, and the healthcare records document capacity assessment and contain copies of a Certificate of Incapacity and Power of Attorney orders. • Where patient does not have capacity to make informed decisions about their care in line with AWI, it is routine practice to engage with significant others to discuss the patient's wishes in relation to their care and record in patients notes. • Getting to Know Me: ○ On diagnosis of dementia (as part of post-diagnostic support) the patients/carers/family are encouraged to complete Getting to Know Me and advised to bring this for all hospital visits. ○ Staff request this on admission and if the patient does not have one, they will provide the document for the patient/family/carer to complete.	• Inconsistent standard of completion of S47 certificates identified through clinical practice. ○ Specialist Nurse in Liaison Psychiatry incorporating best practice into junior doctor induction session. • New AUPR will make more explicit who the patient has consented to being involved in discussions and decision-making.

c) the healthcare records document capacity assessment and contain copies of a Certificate of Incapacity and Power of Attorney orders.	○ Information from the document is used to personalise care planning and provide specific information regarding the person's wishes. • Commitment 10: in line with National recommendations NHS Borders has combined the section 47 Adults with Incapacity (Scotland) Act 2000 documentation to include a treatment plan aiding compliance in completing both. • Where guidance required on compliance with Principles of Adults With Incapacity Act wards can consult with Older Adult Psychiatric Liaison service or Consultant Nurse in Dementia.	

Standard 4: Initial assessment on admission to hospital		
Older people have an initial assessment on admission to hospital, which identifies: • their current health needs and any predisposing conditions which may heighten the risk of healthcare-associated harm • and where care and treatment can most appropriately be provided.		
Criteria	Areas of Strength	Areas in Development
4.1 The initial assessment identifies opportunities to deliver care in community settings where clinically appropriate. Care plans are developed to allow care to be transitioned to community-based teams with specialist knowledge and skills. 4.2 A multidisciplinary care plan is developed and reviewed with the patient (and/or representatives), and includes: a) results of initial and subsequent assessments, for example, comprehensive geriatric assessment, hip fracture pathways, initiation of pathways for the deteriorating patient. b) results of medicines review, including ability to self-manage medication c) planned frequency and dates for care plan reviews, and actions to be taken as part of the review. 4.3 Staff can access additional patient information, such as advanced care plans, anticipatory care plans or the key information summary, where this is available. 4.4 Assessments will be repeated during an acute episode of care when there has been a change in the health status of the patient.	• NHS Borders has ED Fractured Neck Of Femur pathway. • NHS Borders has a Fractured neck of Femur pathway. Adult Unitary Patient Record Update v4 4 J • We aim to achieve 100% med rec for all patients in line with Scottish Patient Safety Programme work. This process is audited across the hospital (medical and surgical). The admission data is collected by the pharmacy team and reports to the monthly medicines reconciliation group. ***(Data included with Standard 6)*** • NHS Borders has a RAD Team (Rapid Assess and Discharge) at "front door" of hospital, i.e. in A&E and Medical Assessment Unit. The AHP led team aims are:- ○ "Turnaround " at front door ○ Prevent inappropriate admissions to downstream wards ○ Facilitate early discharge from assessment unit ○ Early identification of appropriate pathways and/or rehabilitation needs ○ Frailty pathway supported by joint working with OPLS to ensure robust plans are in place for "at risk " groups • OPLS Nurse / "front door Geriatrician" carry out early assessments in MAU to ensure prompt decisions for older patients. There is also a daily MAU board round where	• There are limited options within the Scottish Borders at this time for the older person to receive rehabilitation at home as opposed to hospital. ○ There is one locality "Cheviot Team", a home based, week days only, community rehabilitation and transitional care team, interdisciplinary, including Occupational therapists and physiotherapists ,District Nursing and Health Care Support Workers. ○ At present this team is under review to move to a position of offering the assessment/rehabilitation component to complement an earlier hospital discharge. • There are no specialist dementia beds care beds in care homes at time of report however it is anticipated these will come on-stream later this year.

	appropriate patients are identified for transfer to DME. This is the followed by the frailty huddle to ensure a robust MDT plan for each patient. • At initial assessment and review by Multi-disciplinary team, including geriatrician, will consider if care can be delivered in a community based setting or at home. • Rehab plans/nursing transfer letter/discharge script all go community team delivering care. • Patients in MAU are reviewed by geriatrician daily and MDT discussion at the frailty huddle (Mon –Fri) • Medicine reconciliation carried out on admission. • Access to pharmacy technician who will assess patients ability to manage medication and advise accordingly • All junior Drs can access ECS and eKIS. • Older People's Liaison Service nurses (OPLS)can access mental health notes necessary via EMIS • Patients in DME wards are reviewed 3x week on ward round by geriatrician and daily in MAU. • Nursing assessments are repeated as appropriate to clinical need: • These are audited and monitored using Person Centred Coaching Tool – SCN reviews 5 notes per week.  PCCT Person Centred Coaching To  PCCT Averages.xlsx	

Standard 5: Comprehensive geriatric assessment		
Older people presenting with frailty syndromes have prompt access to a comprehensive geriatric assessment and management by a specialist team.		
Criteria	Areas of Strength	Areas in Development

5.1 A comprehensive geriatric assessment is initiated within 24 hours of admission to hospital by suitably skilled staff for patients presenting with frailty syndromes. Where a CGA is not clinically appropriate, this will be documented in the patient's healthcare record.
 	
5.2 Patients with frailty syndromes reach a specialist geriatric bed within 24 hours of admission.
 	
5.3 Patients with frailty syndromes who require other specialist input (for example, orthopaedics, oncology, palliative care or general surgery), reach the appropriate bed within 24 hours of admission.
 	
5.4 Staff can provide evidence that they have the appropriate experience, specialist knowledge and skills in undertaking comprehensive geriatric assessment.
 	
5.5 Organisations can demonstrate timely access to comprehensive geriatric assessment, specialist beds and teams that are monitored, reviewed and remedial action is taken as appropriate.
	• Elderly patients in hospital requiring rehabilitation are identified through Ward MDTs as to which setting for best outcome, i.e. Community Hospitals, transitional care/home.
	• Patients admitted to MAU will be reviewed by a geriatrician or member of the MDT within 1 day of admission (Mon - Fri) initiating assessment based on CGA principles. (83 patient records reviewed – average time from admission to assessment – 1 day)
	• AHPs working Sundays will initiate their component of Comprehensive Geriatric Assessment.
	• Current availability has a geriatrician "on take" 6/16 weekends at the weekends to initiate assessment.
	• Ortho geriatrics Ward 9 have geriatrician input daily to initiate Comprehensive Geriatric Assessment.
	• Of 133 patients records reviewed:
	  ○ Average LOS on waiting list 1.7 days.
	  ○ Median LOS on waiting list = 1 day
	  ○ 44% transferred on same day as put onto list.
	• Oncology Clinical Nurse Specialist attends daily board round in MAU.
	• Executive team have daily update on number of patients awaiting a bed in DME and how long they have been waiting.
	• Patients, where appropriate, admitted directly to ward 9 from ED.
	• Alerts are placed on Trak-care to alert staff if patients are known to palliative care team.
	• Comprehensive geriatric assessment: Staff (Older People Liaison Services, RAD, and Geriatric Consultants) are able to provide evidence that they have appropriate experience, specialist knowledge and skills in undertaking these assessments.
	• Staff have regular appraisals and
		• Continuous review of assessment practice to improve waiting times to DME & community hospitals.

	opportunities for continuous professional development. • eLearning modules are available in Dementia – at Informed & Skilled Practitioner level, Stress and Distress, Adults with Incapacity, Adult support and protection. • OPLS standing item on DME Unit meeting, any issues can be escalated if necessary and appropriate actions taken. • All AHP staff have training needs identified at yearly appraisals and if requiring a specific rehabilitation skill, this will be identified and addressed with an action plan. • Skill mix team supports training through robust supervision and mentoring. • There are in-house learning opportunities, both uni-professional and multi- professional, CPD and Learnpro, and/or attendance at external courses. • Health care support workers are encouraged to complete relevant NVQ. and competencies training.	

Standard 6: Pharmaceutical care		
Pharmaceutical care contributes to the safe provision of care for older people in hospital.		
Criteria	Areas of Strength	Areas in Development
6.1 There is effective communication with the patient (and/or representatives) about the multidisciplinary care plan, which includes any medication changes, and the long term medication plan when transferring to and from all settings. 6.2 Medicines reconciliation is undertaken within 24 hours of admission and at discharge. 6.3 The multidisciplinary team assesses the patient's (and/or representatives) ability to manage their medicines safely, including **before** discharge. 6.4 At the point of discharge, the patient (and/or representatives) will receive the correct medicines and information to support taking them appropriately. 6.5 The multidisciplinary team will ensure support and monitoring of medicines for patients who require this after discharge. 6.6 National polypharmacy guidelines are implemented. 6.7 A proactive clinical pharmacy service is available and supports medicines reconciliation, review and compliance assessment.	• Patients (and/or representatives) are updated re: ongoing care plan / medication changes by different members of the MDT throughout their hospital stay – these discussions are documented in the patient's notes. These conversations ensure patients / carers understand the changes to their medication which is important for patient safety, particularly where high risk medicines are involved, and encourages patient compliance with their medication. On transfer between care settings this information is provided via the Immediate Discharge Letter (IDL). The pharmacy team and nursing staff will confirm medication changes with the patient prior to discharge / transfer. • All junior doctors (FYs) receive Medicines Reconciliation (Med. Rec.) training by the pharmacy team at the beginning of each rotation. This forms part of their induction training which has been agreed nationally therefore all junior doctors across Scotland will receive training on Med Rec. We aim to complete med rec for all patients in line with Scottish Patient Safety Programme work. This process is audited across the hospital (medical and surgical). The admission data is collected by the pharmacy team and reports to the monthly medicines reconciliation group. ***Sample Data:***  MAU Med Rec Data  Ward 7 Med Rec Data	• The MDT will continue to communicate with patients (and/or representatives) about medication changes and improve on the documentation of these discussions. • Med Rec data collection has largely focused on admission due to the complexities of obtaining this data for discharge as per the Scottish Patient Safety Programme's requirements (which asks that the patients audited for med rec on discharge are the same patients that were audited on admission). A member of staff from the clinical governance team will be attending September's Med Rec meeting to help determine how to collect data for Med Rec on discharge. As part of the Med Rec audit for discharge we can include measuring that changes to medication have been discussed with the patient /carers. • The Med Rec group will continue to collate the audit data and review practice where processes are not being followed. • No audit data for Med Rec available for the community hospitals. At the moment there is no plan to collect this in the imminent future. • The clinical pharmacy service to the community hospitals is under review as currently pharmacy does not have the staff / funding to support this. Funding for a senior pharmacist and a Band 5 pharmacy technician would be required to provide a like-for-like service for the BGH DME patients and the community hospitals patients. Potential changes are in their infancy of planning. The

	Ward 9 Med Rec Data • Medicines reconciliation on admission is captured in the admission documentation, and at discharge is captured on the IDL – this process for discharge has been improved with the introduction of standard IDL templates. For example, an audit conducted in June 2017 on wards 12 and 14 (DME wards) showed that med rec on discharge was completed accurately for 42% of patients (prior to pharmacy input). This was re-audited in June 2018 after a change to the IDL templates and med rec on discharge was completed accurately for 69% of patients. • Within the BGH we have a medicines management pharmacy technician who carries out medicine management assessments. These assessments are recorded using a standardised assessment tool which is kept in the patient's notes. Medicines Management Screeni • RAD, social work, OTs, medical team and nursing staff will also assess patients to different levels and refer patients to the pharmacy team for review where changes in medicines management are required • IDL and medication are issued to all patients at discharge. The clinical pharmacy team review as many of these discharges as possible - where this has been done this will be recorded on the TRAK IDL • Medical and nursing staff discuss ongoing monitoring needs with the patient / carers/ GP / DNs as required. These discussions are documented in the patient's notes and recorded on the IDL. This will also be confirmed again with the patient prior to discharge, particularly for any new medicines	pharmacy team will link with Kenny Mitchell and the redesign team for the community hospitals, taking into consideration the ongoing changes to the pharmacy primary care team in the development of the pharmacotherapy services in line with the new GP contract. • Pharmacy primary care teams working in GP practices will be involved in completing Med Rec within the GP practices for patients discharged back into community • All ward based pharmacy technicians are being trained to complete medicine management assessments to ensure all patients across all wards are proactively being reviewed. • Pharmacy team attend the DDD meetings and support discharge planning by preparing discharges within working hours where possible. • The MDT will continue to communicate with patients (and/or representatives) about medication changes and monitoring needs but we will improve on the documentation of these discussions / arrangements • Medication / Polypharmacy reviews are being carried out but standardised documentation is not used to complete and record this. Members of the pharmacy team are being trained as independent prescribers to support the consistent implementation of these guidelines across all care settings • Polypharmacy reviews for patients on surgical wards are not carried out routinely. Surgical patients are referred back to the GP / primary care pharmacy teams for a review of medication where a polypharmacy review would be appropriate.

	• National guidelines such as the Polypharmacy guidance, Prescription for Excellence and Palliative Care guidelines are being implemented across NHS Borders. Medical teams receive Polypharmacy training at numerous points throughout the year – offered both for those specifically within DME and to the wider medical cohort. For community hospitals, GPs will be implementing these guidelines but this is also supported by the DME consultants • Within the BGH, the clinical pharmacy team (including technicians) has grown in recent years and supports as much work, where possible, at ward level. Pharmacist independent prescribers are able to provide additional pharmacy services across NHS Borders. We currently have 4 pharmacist independent prescribers within the BGH team.	

Standard 7: Assessment and prevention of decline in cognition		
Older people in hospital have their cognitive status assessed and documented.		
Criteria	Areas of Strength	Areas in Development
7.1 A cognitive assessment is undertaken at initial assessment, or where clinically indicated, and documented in the patient's healthcare record. 7.2 As part of the cognitive assessment, acute changes to usual cognitive status are identified and confirmed by the patient and/or representative. 7.3 Any previous diagnosis of dementia, delirium or depression are confirmed and inform care and treatment. 7.4 Wards caring for patients with cognitive impairment or delirium: a) have appropriate lighting and noise levels for the time of day b) provide information that aids communication, for example large signage c) actively encourage the patient's representatives to visit, and be involved with the patient's care if they usually do so, and d) promote healthy sleep and encourage a normal sleep pattern.	• 4AT is embedded in documentation and carried out on all patients over the age of 65 on MAU. • Where indicated, this is repeated if there is a change to patients presentation and recorded in patients AUPR. • Collateral information is obtained at the earliest opportunity to establish sudden changes in patients cognition. • Staff use the Single Question in Delirium (SQiD) to identify change in patient's condition. • Previous diagnosis of dementia, delirium, or depression are confirmed via Emis, Liaison Psychiatry or MH Older Adult Service and inform care and treatment during admission. • Delirium training has been delivered to all staff on ward 12. • Delirium training is also routinely offered in the Borders General Hospital and Community Hospitals by the Older Adult Liaison Psychiatry team. • There are information posters and leaflets widely available on wards which explain delirium and these are made available to patients and their families. • Environmental audits have been carried out on DME, Kelso Community Hospital and are due to be undertaken on other appropriate areas. • Signage throughout the hospital has been adapted to reflect best practice in dementia recommendations. • Hospital has supported "Johns Campaign" and have open visiting and overnight stay areas, actively encouraging relatives to be collaborative partners in care delivery and assessment of future needs.	• 4AT is not consistently carried out despite being promoted by nursing staff and senior medical team. • Where person is moved to another ward, follow-up 4AT may be delayed or missed. • Orientation boards are needed in all ward areas.

Standard 8: Delirium		
Older people in hospital experiencing an episode of delirium are assessed, treated and managed appropriately.		
Criteria	Areas of Strength	Areas in Development
8.1 Patients with a diagnosis of delirium have common causes of delirium considered and documented, and their management and progress reviewed by the multidisciplinary team. 8.2 If, during comprehensive geriatric assessment, a new cognitive abnormality or a sudden change in cognition is identified, the patient will be assessed for delirium. 8.3 Monitoring for delirium will continue until the patient is either cognitively settled, delirium is confirmed, or an alternative diagnosis is confirmed. 8.4 Capacity to consent to treatment is assessed and documented for patients for whom delirium is ongoing after initial treatment. 8.5 Staff, and the patient's representative, are made aware when a patient has been diagnosed with delirium.	• There is increased awareness of delirium as a syndrome and delirium diagnosis is routinely recorded in the patient's notes. • Clinicians routinely and habitually initiate basic screening measures for physical causes. • Cognitive screening of all adults over the age of 65 using the 4AT is part of initial assessment on admission to hospital. • Where dementia is known or suspected, staff follow Protocol for management of people with cognitive impairment or dementia presenting to the Borders General Hospital. • Many staff across the hospital have undertaken delirium training modules on Learnpro. • Liaison Psychiatry Nurse Specialist has undertaken bespoke delirium training sessions with Medical, Nursing and AHP staff. • There is now a stock of delirium Awareness leaflets for patients and families and Delirium toolkits for staff. These have been circulated to all ward areas and there is evidence that patients and families have found these beneficial • Wards 10 and 12 also have a patient "Welcome pack" which includes these resources. • There are leaflet stations across the hospital containing a range of Alzheimer Scotland leaflets, AWI/Power of Attorney leaflets. There are also 'Think Delirium' posters in all in-patient units and Scottish Delirium Association Pathway poster on appropriate clinical areas. • Where Cognitive impairment impacts on recovery/re-enablement or where presentation is a cause for concern direct referral by telephone/email to Mental health older people liaison service is available. • A pathway has been developed for clinicians	• Delirium screening is not embedded in surgical/orthopaedic areas of the BGH. • There is further training needed in Orthopaedic and Surgical areas and ward 5. • The TiME Bundle in delirium is not well embedded into the wards. • A review of diagnosis of delirium is underway with a view to embedding the TIME Bundle for use in ED and MAU. • It would be useful to audit the numbers of people who have received this information and to obtain feedback, through satisfaction surveys, in order to measure any and what tangible benefit these have had. • Whilst this pathway has been in place for several years, there is a lack of evidence that patients have been referred to the community mental health team and many patients who have been delirious are not being referred onward for further assessment. • The ward environments through most of the BGH are not delirium/dementia friendly. Lighting, noise and orientation points all pose problems for people with delirium. • Other ward areas, where people with delirium receive care have not yet had any environmental audit. • Assessment of capacity performance has slipped and improvement work is needed to understand the reasons for this. • There remains a lack of understanding as to the nature of legal capacity and to the ethos of presumed capacity.

	to refer patients who have been delirious to either the Liaison teams Delirium call back clinic or onwards to the Older Adults community mental health team. • Environmental audits for people with cognitive impairment have been undertaken in DME ward 14 and are in progress on DME ward 12. • Signage across the BGH campus has been changed to support people with cognitive and visual impairments. • In cases where cognitive impairment does not resolve, there is a pathway for staff to refer to the Liaison Psychiatry Nurse Specialist for Older Adults. • S47 and treatment plans are frequently now completed for people who are diagnosed with delirium and are kept under regular review.	

Standard 9: Dementia		
Older people in hospital with a confirmed or suspected diagnosis of dementia receive high quality care.		
Criteria	Areas of Strength	Areas in Development

9.1 Patients with a diagnosis of dementia have this documented together with their baseline level of cognition and function, and current care and support provision on admission to hospital.
 	
9.2 Patients with dementia receive high quality care in hospital which reflects current best practice such as the *Standards of Care for Dementia in Scotland* and *the 10 Care Actions.*
 	
9.3 When a new diagnosis of dementia is suspected and depending on symptoms and severity, patients are referred:
a) to the specialist older people mental health liaison team during admission, and
b) for post-discharge follow-up by either a community mental health team for older people or a primary care team.
	• People with a diagnosis of dementia on admission have this recorded in their notes as part of past medical history and current problems.
	• Current support and level of ability is recorded in admission documentation.
	• Nursing staff can access Mental Health background and support through EMIS if required.
	• Baseline cognitive assessment using 4AT is undertaken on admission.
	• Further assessment of cognitive function is made where clinically appropriate:
	  ○ To inform capacity assessment
	  ○ To support care planning
	  ○ To support discharge planning
	  ○ This should then be recorded in the patient's notes.
	• Few people who are given a diagnosis of dementia during admission to hospital, but in the cases where this happens this is recorded on discharge letter and is passed to the primary care dementia register.
	• Individualised patient care plans have been developed and PDSA improvement methodology cycles employed to measure the efficacy – these form the basis of the care plans now embedded in new AUPR.
	• Getting To Know Me [GTKM] documentation is sought from all people with an identified or suspected dementia to inform person centered- care
	• The use of "What Matters to Me" [WMTM] is widespread across the hospital to inform individualised care needs and preferences – with mixed efficacy.
	• There is wide spread training across the hospital on dementia care, mapped against the Promoting Excellence framework, with E-Learning available at Informed, Skilled and Enhanced practice levels.
	• Nursing and AHPs are the highest recipients of dementia care training.
	• Stress and distress 2 day and bite-sized
		• "What Matters To Me" (WMTM) and Getting To Know Me (G2KM) whilst in evidence, do not always inform care on a daily basis - these are more firmly embedded into the new Adult Unitary Patient Record to better inform care planning.
		• There is a need for more face-to-face learning opportunities – the appointment of Dementia Nurse Consultant in May 2018 will enhance those opportunities.
		• There has been little uptake in the attendance of stress and distress training by hospital staff across both the BGH and the Community Hospitals.
		• Work in relation to Commitment 10 has lost focus without Dementia Nurse Consultant in post and it is anticipated that this work will be invigorated following appointment in May 2018.
		• Competing demand on Dementia Champions has led to limited success in their role.
		 
		Commitment 10 update 13.8.18.docx
		• MWC for Scotland undertook themed visit to community hospitals. Dementia Nurse Consultant has developed action plan which is at an advanced stage however is yet to be signed off.

	modules have been made specifically available to hospital staff. • Training figures show that in the last year there has been continued take-up of the Dementia Informed Practitioner and Adults with Incapacity Act despite the absence of a Dementia Nurse Consultant to drive this forward.  Dementia Training Run Chart.xlsx • There remains a keen uptake in the dementia champions programme an the next cohort of candidates has just been processed. The hospital has sent candidates to every cohort since the Dementia Champions programmes inception. • The hospital has a standard to assess the cognition of all adults over the age of 65 on admission. • Tools are in place to undertake such an assessment • There is a commitment to re-assess cognition further into the person's admission where there is a notable change in cognition or functioning. • Where dementia is known, this is recorded on the persons admission paperwork and assessment is undertaken to establish baseline cognition. • Staff can access electronic databases to ascertain whether or not the person is known to a community mental health team or worker and that worker can be contacted directly to support the person.	

Standard 10: Depression		
Older people in hospital with a confirmed or suspected diagnosis of depression receive care and have appropriate management and interventions put in place to minimise decline and contribute to quicker recovery.		
Criteria	Areas of Strength	Areas in Development
10.1 Patients with a confirmed or preliminary diagnosis of depression on admission, including those with a primary diagnosis of dementia, have this documented. 10.2 If assessment indicates possible depression, this is documented and a care plan agreed. 10.3 Patients in hospital with a diagnosis of depression (confirmed or suspected) are referred to: a) specialist older people mental health liaison team (if input is required during admission) b) community mental health team for older people or c) a primary care team on discharge, or condition-specific specialists.	• Patients with a known diagnosis of depression on admission have this recorded as both part of their medical history and current problem/presentation. • Where considered appropriate, if Mental Health services are involved with a patient they are alerted and interventions during admission discussed and recorded in patient record. • Patients who are presenting with low mood or suspicion of depression are referred to the Liaison Psychiatry team including: • Part-time Consultant Psychiatrist. • Specialist Nurse in Liaison Psychiatry in Borders General Hospital. • 2 x Liaison Nurses working into Community Hospitals. • Ward staff are aware of their roles and responsibilities in relation to the local referral processes to specialist or community teams. • Depression is noted in the discharge letter to promote follow-up or onward referral where appropriate.	• There remains a lack of use of appropriate assessment tools (e.g. HADS, PHQ-9, Cornell, GDS) by wards before referring to psychiatry – which may reflect a lack of expertise. • This may explain why there often referrals to psychiatry for understandable low mood, where no symptoms of depression are evident • There is still a high number of referrals where greater ward interaction could be the solution but Psychiatry seems an 'easy alternative'. • There is still a lack of consent sought from patients, prior to a referral to psychiatry. • There is a need for Medical, Nursing and AHP staff training in the clinical symptoms and approaches to depression in the general hospital and of the risks of anti-depressant prescribing. • There are limited resources and services for older people including psychological therapies. • Limited knowledge of low mood and suicidality among nursing staff has been identified as an area of weakness and discussions are underway with public health as to how to deliver a realistic, effective training programme.

Standard 11: Falls prevention management		
Older people in hospital are assessed for their risk of falls within 24 hours of admission, and have appropriate measures put in place to reduce that risk.		
Criteria	Areas of Strength	Areas in Development
11.1 A falls risk assessment is initiated within 24 hours of admission. 11.2 Patients with identified falls risk factors have a care plan for meeting those needs or mitigating those risks which: a) is developed with the patient (and/or representative) b) is shared in an appropriate format, and c) includes a medicines review. 11.3 A clear falls prevention plan is documented and shared with the multidisciplinary team on discharge or transition between care settings. 11.4 Staff can deliver safe and effective falls prevention and management. 11.5 Clear process and protocols are in place for the organisation to review, record, share information and monitor all falls in hospital.	Back to Basics – Forward to Excellence programme has provided a focus for reduction in falls with harm. • Assessment of patients for risk of falls, and completion and review of the person centred falls bundle with relentless focus as evidence in MAU work 2017 (no falls with harm for 162 days. SCN dashboard.) • Working with ED to identify patients who present with falls and other injury who are admitted to ensure if they re admitted they are in the right place at the right time. • Relentless focus and staff ownership and engagement – human factor for improvement this is evidence based through Scottish Patient Safety Programme. • Working with psychologist on fear of falling and the project. • Placement of patients in ward near nurses station and/or cohorting for patients at risk. • Use of slipper or grip socks this is evidence based worldwide – re improves foot placement and walking compared to walking barefoot. • Use of closer observation by nursing is important but only in certain groups of patients and not all falls risk. • Review of falls timely through datix process- we are testing post fall safety huddles Monday to Friday on acute site – clinical improvement facilitor goes to HSB picks up falls goes to ward and has a set of questions to work through with the MDT agree actions and copies are given to SCN/CNM and GM. • Education and training of staff in prevention and management of falls. • In addition to: ○ knowing how to carry out a lying and standing BP properly	• Care plans: : • THE PERSON CENTRED FALLS BUNDLE – is designed to ensure we engage with families/carers/partners etc to inform what care planning is required to reduce the risk of the patient falling. This will incorporate all of the professional clinical assessment. • Currently we know there is wide variation and we need to ensure we are all encouraging the realistic medicine approach to risk assessment and planned management. • As we are assessing patients risk there is the falls pathway to consider (see attached doc 2, to ensure we are covering all aspects as one size does not fit all but requires a Person centred approach eg assessment of continence, delirium, medication, etc).  Falls pathway NHS Borders V1 2 June 2 • It is considered that shared risk with patient/carer/family may reduce restrictions placed on patient (E.G. Reducing close observations.) • Currently Medicine Reconciliation does not include the list of medications which contribute to falls. All areas have a laminated sheet of low, medium and high risk meds. • We are testing “polypharmacy” stickers as a prompt for patients at risk of falls. • If effective this will be put on the PCFB as a identified issue as well as on the patients drug kardex. • Work under way to standardize leaflets across pathway eg Up and About

	○ knowing what medications can contribute to patients falls - classification of drugs ○ polypharmacy. ○ Learning sessions on falls and QI – Jan, April, August 2018 – shared learning from specialist experts locally and from other boards. • Use of technology when appropriate for certain groups of patients *eg patients distress can increase with the noise of bed/chair sensors where patients want to get away from the noise and therefore at more risk of falls.* • Scoping of all wards across acute, mental health and community hospital on improvement package as detailed above. • Link nurses in all acute, mental health and Community hospitals • QI support attached to the wards as above. • Falls working group – reviewing all policies, guidelines and data • Falls strategy group- wide stakeholders across all professions, partners, fire and rescue, SAS, care home managers and SBC- working on strategy for NHSB.  Falls July 2018 data.doc	• Patient placement in wards which includes understanding of where all falls are happening and why- e g using datix information and measles mapping of wards. • Work is underway to create ownership at ward level – through SCN's development programme. • Working toward at a glance identification of patients in ward at a glance who are a falls risk without labeling • Previous response to planning has been reactive – falls work now moving towards QI methodology approach. Testing with support from QI skilled and trained staff assigned to wards in acute, mental health and community hospitals. • Any falls will be identified at the hospital wide safety huddle Monday to Friday 830am. Clinical Improvement Facilitor will come to the ward and discuss the fall using the proforma attached with MDT who are caring for the patient.  Learning from a fall draft 2 7 18 V2.doc ○ It is envisaged this will also help timely review and actions on datix as well as being proactive in reducing all falls. ○ Early indication works well, only takes 10 mins ○ The form will be photocopied and sent to SCN/CNM & GM for the ward/divison. ○ The form can be used when to review datix and can be scanned and attached. This may reduce the time it takes to go through the datix approval and can be used for learning from events in the clinical governance for your divisions and wider organisational learning. • B2B operational group – stakeholders SCN/SCM/CNM we will create ownership and the will to improve.

		• Ward level staff knowing their data- we are data rich and the feedback is there is so much we don't know what to do about it- through the above and the improvement work we will tackle this as well as learning sessions through falls days etc where link nurses and others are introduced to basics of QI this will be addressed. • SCN owning PCCT and applying the principles consistently- again working with them to take this forward the process. • Working with SAS, Fire and Rescue and district nurses on community falls. • There are a number of environmental issues- reducing clutter, ergonomics of toilets, bathroom, lighting, colours – Falls work will support environmental assessment aligning with dementia nurses assessment as there are synergies.

Standard 12: Rehabilitation		
Older people in hospital have access to rehabilitation services that are timely, accessible and person-centred.		
Criteria	Areas of Strength	Areas in Development
12.1 A multidisciplinary rehabilitation plan is developed with the patient (and/or representative), and includes: a) goals and outcomes that are specific, measurable, achievable, realistic and timed (SMART) b) details of support for the patient (and/or representative) to maintain their skills and function in hospital while they wait for discharge, and c) regular reviews and updates of agreed goals and outcomes. 12.2 The patient receives a rehabilitation plan, which is delivered in a timely manner and in an appropriate setting for the patient. 12.3 Rehabilitation is carried out by a multidisciplinary team who are trained and skilled in delivering rehabilitation, enablement and developing personal goals and personal outcomes. 12.4 The organisation can provide evidence of how rehabilitation services are delivered including: a) rapid provision of equipment for example, equipment or adaptations to the patient's home (including care homes), and b) availability of alternative facilities to a hospital ward (including their home or homely setting) for the older person to receive their rehabilitation, where it is clinically appropriate and safe to do so.	• Nursing, Medical and Allied health professionals are integral to the rehabilitation provision within BGH and of the 4 Community Hospitals. • AHP staff work a 5 day week and patient rehabilitation continues 7 days a week within the wider MDT team working to agreed plans. • The BGH has 59 assessment and rehabilitation beds within the Department of Medicine for Elderly and includes patients (e.g. Surgical, Medical and Orthopedic) who are no longer on a condition specific pathway or medically unwell, but require further rehabilitation. Elderly stroke patients will remain either on the Stroke Ward or be transferred to their local Community Hospital for their rehabilitation. • To be treated closer to home when medically stable, patient's requiring rehabilitation will have the opportunity to return to Community Hospitals. Central Borders patients remain within the BGH as there is no Community Hospital. • The Community Hospitals' designs afford an improving rehabilitations environment, easy access for outdoor mobility, dining room, lounge, individualized toilet/shower and an AHP department . • Occupational Therapy and Physiotherapy formulate a rehabilitation action plan, following patient non–standardized and standardized assessment. This is recorded within unitary patient records and will be reviewed at weekly MDTs, with times, estimated discharge dates agreed timeously to facilitate smooth transitions. • Rehabilitation plans are patient centered and for safe and effective care - "What Matters to Me". In Community Hospitals, following on from MDT, the patient and/or carer is informed of the meeting outcomes and engaged in discussion of rehabilitation goals,	• The environment within the BGH Wards has limitations for rehabilitation. Sited on the first floor of the hospital, a 6 bedded bay only allows for an individual bed and chair space. No social or dining space available and the ward siting reduces the access to outdoors and mobility. • There is one toilet and/or shower in the bay, so patient's personal care activities are regularly carried out at their bedside. • Activity prescriptions are not currently used in the community hospitals. • The Central Equipment Store does not operate a public holiday, weekend or out of hours service, but has potential for times review within scope of new ways of working. • SMART provide a national driving assessment service, which is over subscribed. • There are limited options within the Scottish Borders at this time for the older person to receive rehabilitation at home as opposed to hospital. There is one locality "Cheviot Team", a home based, week days only, community rehabilitation and transitional care team, interdisciplinary, including Occupational therapists and physiotherapists ,District Nursing and Health Care Support Workers. At present this team is under review to move to a position of offering the assessment/rehabilitation component to complement an earlier hospital discharge. • While patient's discharged home, requiring further rehabilitation, have the opportunity to attend at one of 5 Day Hospitals, sited within Scottish Borders - there is no such facility available within the Central Borders.

	care plan and discharge plans. • The wider team members will be involved in planning, delivering and discharge, as required, e.g. Specialist Nurses services, sensory services, third sector. • Good nutritional care is essential to a patient's rehabilitation and timely discharge from hospital. Patient/carer education is provided through the dietetic department; alongside Specialist Nutricia Nurses pre and post discharge for those patients being enterally tube fed. If ongoing support is required after discharge referral is made to the community dietetic team. • The wider MDT , and in particular the nursing staff and HCSW on the wards, provide a very enthusiastic and positive approach to the rehabilitation process. • Health care support workers work together with AHP's in achieving patient's goals. • The nursing staff in care of the elderly have embraced "End PJ Paralysis" focusing on the enablement of hospitalized patients to get up, dressed and moving in order to prevent de-conditioning. • The MDT led by the AHP's are formulating activity prescriptions for patients supported by health care support workers. All actively promote the philosophy of "rehabilitation is everyone's business" to support patients to gain and maintain their skills and function whilst moving to discharge. • Elderly patients in hospital requiring rehabilitation are identified through Ward MDTs as to which setting for best outcome, i.e. maybe Community Hospitals, transitional care, etc. • NHS Borders has a RAD Team (Rapid Assess and Discharge) at "front door" of hospital, i.e. in A&E and Medical Assessment Unit. The AHP led team aims are:- o "Turnaround " at front door o Prevent inappropriate admissions to downstream wards o Facilitate early discharge from assessment unit o Early identification of appropriate	

	pathways and/or rehabilitation needs. ○ Frailty pathway supported by joint working with OPLS to ensure robust plans are in place for “at risk “ groups. • All AHP staff have training needs identified at yearly appraisals and if requiring a specific rehabilitation skill, this will be identified and addressed with an action plan. • Skill mix team supports skill training through robust supervision and mentoring. • There are in-house learning opportunities, both uni-professional and multi- professional, CPD and Learnpro, and/or attendance at external courses. • Health care support workers are encouraged to complete relevant NVQ. and competencies training. • AHP staff are aligned to specialist services/wards within BGH and to the community hospitals. Appropriately skilled staff provide a flexible work force to support equity of access and flow. • The Scottish Borders have a community equipment store, jointly funded by Health and Social Care and managed by SB Care. In recent months the store has moved to larger, more modern premises and a review has been undertaken of core and non-core stock. • Core stock items have been made available within satellite stores and the BGH in the Scottish Borders to be readily accessible to facilitate rapid discharge/prevent admission where equipment needs require to be met. • Equipment needs of Care Home clients, specifically “bespoke“ chairs are met through Joint Health and Social Care funding. • To facilitate rapid discharges from hospital to Care Homes, the community equipment store (CES) is able to arrange “short term equipment hires”. • The equipment budget has not had any financial uplift and in the last two years has required extra funding midway through the	

	Financial Year and has instated a scrutiny panel of MDT professional staff to oversee governance of assessment and supply of "critical" and "substantial" equipment requests. Principal assessors for equipment are AHP and Nursing staff. • Wheelchair and special seating assessment and provision are purchased from SMART Centre in Edinburgh. Their other included services to NHS Borders are prosthetics, orthotics and bioengineering services, electronic assistive technologies, custom design service, a disabled living centre and gait analysis. • The Red Cross Voluntary Service within Scottish Borders provide an efficient short-term loan service for wheel chairs. Self propelled wheelchairs can be provided through this voluntary service to allow an inpatient to commence their rehab program whilst awaiting SMART provision. Scottish Care and Repair service is provide by Eildon Housing in partnership with Scottish Borders Council. Handyperson Service, Adaptations Service and Home Improvements Advice are all provided. An Occupational Therapist(s) is employed within the Service. Provision of requested handrails/grab bars at home are promptly fitted. • Patient's discharged home, requiring further rehabilitation, have the opportunity to attend at one of 5 Day Hospitals, sited within Scottish Borders. • Rehabilitation within Day Hospitals is carried out by dedicated MDT teams, there is flexibility in that one or more of the treatment sessions may be carried out within the patient's home. Day Hospitals are able to offer other patients interventions, e.g. Falls Programs , Parkinson's Disease Clinics. • Adults who are clinically and functionally fit for discharge who will not be able to return home fully independent of aids, adaptations and/or social care services are referred to the hospital based social work service upon completion of the persons (or their representatives) informed consent.	

	18 months ago SBC, NHSB & SB Cares commenced a project in Waverley, a Local Authority Residential Care Home with the aim of providing a period of short-term rehabilitation (maximum 6 week period) to people. The project designated 16 beds for transitional care supporting service users to return to their own home as independently as possible. Clear rehabilitation goals are identified in order to admit and reviewed weekly at MDT meetings. An assessment of needs, including home assessment visits prior to discharge home, is carried out to ensure that care and equipment is in place for a safe discharge. Data collections are proving very positive to successful project outcomes. • The Transitional Care Facility has been successful in achieving its aims and has facilitated 99 hospital discharges - patients who were medically fit and did not need to be in hospital but who were not yet able to be discharged home safely. Without a facility such as TCF then these patients would likely have remained in hospital. o 81% of those service users admitted return to their own home. o 67% of all stays people have been discharged to their own home within 6 weeks. o A total of 3,352 occupied bed days have been taken up in Waverley, which are potential bed days saved in an acute hospital setting. • Future review of model will explore whether rehabilitation can be effectively delivered from home rather than TC , See “Hospital to Home” model in Eildon/Central. A short-term pilot of “Hospital to Home” model within Berwickshire and Teviot has commenced and has plans in place to extend to Eildon/Central. • The aim is to ensure appropriate support is available for patients in their own home, to promote independence and discharge patients in a more timely manner.	

	• The care at home, for up to 6 weeks, will be provided via Health Care Support Workers with an enablement approach. Further monies are being applied for in the Eildon/central Team , to provide the addition of occupational therapy and physiotherapy to focus on early supported discharge, and prevention of a hospital admission .  H2H Berwickshire Monitoring Report (as	

Standard 13: Pre-discharge planning		
Effective discharge planning is a continual process and starts as soon after admission as possible, or before admission for planned admissions. Communication, including transfer of information between healthcare and social care professionals, is essential to a seamless process of transition.		
Criteria	Areas of Strength	Areas in Development
13.1 A multidisciplinary discharge plan is developed with the patient, including those with cognitive impairment (and/or representatives), and includes: a) details of specialist assessments (for example, a comprehensive geriatric assessment) and outcomes b) details of future care plans and/or referrals to specialist, community or primary care, and c) consent obtained from those with power of attorney or legal guardians where a patient does not have capacity. 13.2 The patient's representative is involved in discharge planning with the patient's consent and can access carer advice and support if required. 13.3 For new episodes of cognitive impairment or depression identified during admission, the diagnosis and any residual symptoms are clearly documented on the discharge letter and communicated to the patient (and/or representative), the primary care team, and any condition specific specialist teams for appropriate follow-up. 13.4 The immediate discharge letter is sent to the GP within five working days of the patient's discharge. 13.5 Primary care and other health and social care community teams are informed of discharge plan.	• Medical wards do operate a multi-disciplinary approach to discharge planning the vast majority of older adults do have a robust written discharge plan in the Unitary Patient Notes, which are regularly audited by Nurse Leads to ensure this standard is being achieved. • Where an adult consents to a social work assessment (or legal proxy if the adult no longer retains sufficient capacity to consent to assessment) the assessment undertaken by the hospital social worker reflects the professional views of members of the multi-disciplinary team as well as the thoughts and experiences of the adult and their carer. • The assessment produces outcomes and indicates which outcomes are critical to the safest discharge plan. • The discharge letter also reflects the multi-discipline teams decisions and services that are in place and those that will be required to achieve the agreed outcomes. • The social work assessment also considers current and future/potential risks to the adult and their carer in implementing the discharge plan. • In addition, the assessment highlights how these risks can be mitigated and decisions made by the adult and their carer regarding how risks will be managed. • All risk assessments are audited by the social work team manager before discharge from hospital proceeds and any gaps in planning identified for remedial action. • Social Workers do not commence an assessment without written consent from the adult or their legal proxy and this document is stored within the local authority's electronic recording systems. • Social work compliance with this requirement is frequently audited. • Where ○ there are no legal powers in place	National Day of Care Audit highlighted that: • Medical wards do take a multi-disciplinary approach to discharge planning, two surgical wards in the BGH do not plan for discharge using a multi-disciplinary approach. ○ Engagement with key professionals is planned in order to develop a clear pathway for discharge planning for older adults on surgical wards. ○ Appropriate documentation will be developed to support implementation of discharge planning on surgical wards for adults. National Day of Care Audit also highlighted that: • Each of the community hospitals have a different approach to multi-disciplinary team discharge planning. ○ Documentation on the roles and responsibilities of MDT being re-drafted aiming to develop a more standardized but nonetheless locality sensitive approach to discharge planning can be agreed and implemented. ○ General Managers for Primary and Community Care and for Patient Pathways are engaging with key partners to redraft and refine this documentation. ○ MDTs will then be supported by the two General Managers to implement agreed procedures and practices. • Where possible the management of risks includes anticipatory care planning but this

	○ the adult no longer retains capacity ○ a section 47 certificate is in place the views of the consultant are requested whether or not a social work assessment can commence - where all professionals and the carer are in agreement and it can be considered to be a part of the care plan for the adult while in hospital. This decision is recorded on the Unitary Patient Record. • Carers are fully involved in the assessment process and their input is seen as crucial to the assessment by social workers where the adult has given consent for this involvement. • New episodes of cognitive impairment are included in discharge letter to prompt further investigation. • Cases of delirium identified where concerns remain on discharge can be referred to the delirium follow-up clinic run by Older Persons Psychiatric Liaison Nurse and Head of Psychology for Older Adults. • In the few cases where dementia is diagnosed while in hospital. ○ Discharge letter informs GP. ○ Referral to MHOAS for Post-diagnostic support. ○ Patients are added to the primary care dementia register. • The Ward informs District Nurses of discharge plan which is documented in the UPR. • Social work informs locality social work teams and the care provider, which is evidenced through MOSAIC. • All adults referred to social work services are offered an assessment of needs as well as signposting to other relevant agencies and service providers. • The quality of social work services offered to adults in hospital is audited by the local authority and shared with the IJB and NHS through the Joint Older Adults Strategy Group for the purpose of developing strategy and driving continual improvements.	aspect of the assessment and planning process has weaknesses and further work on anticipatory care planning has identified as a priority for the current financial year by the IJB. The work is being led by the General Manager, Patient Pathways. • Social worker puts a detailed case note onto Mosaic and/or copy documentation as this is either requested by the adult or their legal proxy and would be guided by the adult and/or their legal proxy about what details are put into the assessment i.e. need to know basis.

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

14.1 There is a co-ordinated person-centred approach to care transitions for older people in hospital, which includes the patient's representative where appropriate.
 	
14.2 Effectiveness is monitored in terms of patient (and/or representative) experience as well as service impact.
 	
14.3 The patient will have access to a health or social care member of staff who is responsible for co-ordinating their transition back to the community in collaboration with all relevant agencies.
 	
14.4 The care and support needs of patients who are delayed from hospital discharge are reviewed weekly.
	• We have the site daily 0830am and 1345 huddles to coordinate hospital-wide transitions of care.
	• This includes representation from the whole hospital; nursing leadership, medical leadership, AHPs, Pharmacy, Site & Capacity, Social Care and support services.
	• Social Workers do not commence an assessment without written consent from the adult or their legal proxy and this document is stored within the local authority's electronic recording systems.
	• Social work compliance with this requirement is frequently audited. Where there are no legal powers in place and the adult no longer retains capacity and a section 47 certificate is in place the views of the consultant are requested with regards to whether or not a social work assessment can commence where all professionals and the carer are in agreement and it can be considered to be a part of the care plan for the adult while in hospital. This decision is recorded on the Unitary Patient Record.
	• Carers are fully involved in the assessment process and their input is seen as crucial to the assessment by social workers where the adult has given consent for this involvement.
		• We are working to create more virtual systems to plan transfers into the community.
		• We do not have an End Of Life Care Pathway which supports rapid discharge from hospital to facilitate end of life care at home. We are working toward an end of life care facilitator to identify and facilitate complex discharges.
		  ○ Develop a Margaret Kerr Team to provide accessible and equitable support to deliver PEOLC in community settings.
		  ○ A more proactive approach to end of life anticipatory care planning.
		  ○ Allow resources within the MK support team to be used to support earlier discharge, re-enablement activities and good quality end of life care at home.
		
		 
		Project Overview no costs.docx

Standard 15: Patient pathway and flow		
Older people in hospital are cared for in the right place at the right time.		
Criteria	Areas of Strength	Areas in Development
15.1 Boarding of any patient is minimised. 15.2 Arrangements are in place to improve flow for older people to ensure that the right	• Current practice recognises boarding as unavoidable at times, but will always strive to keep patients within clinically appropriate areas, discharge is preferable to boarding if	• The boarding policy is being reviewed ahead of this winter with an aim to further reduce instances of multiple boarding and avoid boarding older, frail patients from the front

patient is cared for in the right way, in the right place at the right time. 15.3 Systems and processes are in place to minimise the potential patient safety risks and poorer outcomes associated with patients not being cared for in the right place. 15.4 Organisations demonstrate adherence to transfer policies to ensure that hospital moves add value for patient care and are due to clinical need and not service pressures. 15.5 Patients with cognitive impairment are not moved to another bed, room or ward unless clinically necessary for their treatment or to manage clinical risks. 15.6 If, after multidisciplinary team agreement, the patient is moved, the reason for the move is clearly documented and shared with the patient (and/or their representative).	clinically appropriate. • There is a Standard Operating Procedure, 'Boarding patients out with Speciality in the Borders General Hospital' which states , '*Older frail patients should be moved in hospital as little as possible, and never out-of-hours for non-clinical reasons. Patients with cognitive impairment, delirium, dementia or a learning disability should not be boarded out with speciality unless this is clinically necessary.*' • There is a risk assessment for boarding on the back of the 'Patient Transfer Sheet' to encourage safe boarding practices. • OPLS Nurse / "front door Geriatrician" carry out early assessments in MAU to ensure prompt decisions for older patients. There is also a daily MAU board round where appropriate patients are identified for transfer to DME. This is the followed by the frailty huddle to ensure a robust MDT plan for each patient. • Geriatrician led ward rounds operate in Orthopaedics, again to ensure early identification of patients suitable for transfer to DME and the right care for older patients out-with DME. • Patients identified for DME who remain in MAU for whatever reason have ongoing Older Person's Liaison Service support and Geriatrician input. • Patients in MAU identified for DME are not moved to other wards unless it is unavoidable. The decision to transfer a patient from MAU to DME is documented to ensure clarity in value of move. • A new monthly Unscheduled Care Improvement Forum has been established to lead improvement in patient flow. The forum planned for 28/08/18 will focus on Delayed Discharge and the 25/09/18 meeting on 'safer boarding'.	door. • A programme of work is being undertaken to improve flow through the BGH and build resilience ahead of this winter. The latest version is attached and details improvement activities in a number of areas: o Rolling out of Daily Dynamic Discharge programme to strengthen ward processes that deliver flow o Recruitment of new Site & Capacity team to manage flow o Further development of ambulatory care pathways o Strengthening of flow management processes within the hospital o Establishment of > 28 day length of stay group to ensure robust management of those patients with a longer LOS.  NHS Borders Unscheduled Care Ac  BGH Unscheduled Care Improvement Mi

Standard 16: Skills mix and staffing levels		
Older people in hospital are cared for by knowledgeable and skilled staff, with care provided at a safe staffing level.		
Criteria	Areas of Strength	Areas in Development

16.1 Training in the knowledge and skills to care for older people in hospital is available to all staff, including support staff.
16.2 Staff demonstrate the knowledge, skills and competencies necessary within their role for the delivery of safe and effective care for older people, including awareness of carer involvement.
16.3 Staff who care for people with cognitive impairment or dementia are trained in line with the *Promoting Excellence* framework.
16.4 Staff training is available for the identification and management of depression in older people.
16.5 There are clear processes in place to demonstrate safe staffing levels with the appropriate skills mix.
16.6 For nursing staff, workforce planning tools are implemented.
16.7 There are clear processes in place for staff to escalate any concerns about staffing levels and there are associated plans to mitigate safety risk.
16.8 There are processes in place for the monitoring of multidisciplinary staffing levels and skills mix.
16.9 Professional accountability for senior clinical decision-making is clear and is complemented by clinical leadership, supervision and support for staff.
	• In addition to education and training of staff in simple prevention and management of falls.
	  ○ knowing how to carry out a lying and standing BP properly
	  ○ knowing what medications can contribute to patients falls
	  ○ classification of drugs, polypharmacy
	Back2Basics Quality Improvement programme focusing on:
	  • Falls
	  • Tissue Viability
	  • The deteriorating Patient
	  • Communication
	  • Food Fluid and Nutrition
	  • Learning sessions on falls and QI – Jan, April, August 2018 – shared learning from specialist experts locally and from other boards.
	  • Tissue Viability and QI with shared learning.
	  • Communication and QI.
	• Link nurses for key areas of practice.
	  ○ Falls
	  ○ Tissue Viability
	  ○ Food Fluid and Nutrition.
	  ○ Dementia Champions.
	• A commitment to QI training across NHS Borders with 20 staff trained to use a QI approach through a number of national programmes.
	• Wide spread training across the hospital on dementia care, mapped against the Promoting Excellence framework, with E-Learning available at Informed, Skilled and Enhanced practice levels.
	• Stress and distress 2 day and bite-sized modules have been made specifically
		• MUST training has been delivered to 98% of registered staff and HCSW across the BGH but is yet to completed for MH staff and community hospitals – this wil be completed by end of September 2018.
		• NLAB (Nursing Leadership Academy Borders) programme – releasing SCNs for one day/month to develop expertise in QI & Practice Development tools to apply within their ward settings.
		• Fundamental skills Registered Nurse & HCSW programmes were introduced in February 2018 to incorporate, Life Support, Infection Control, Anticoagulation, Deteriorating patient, Food, Fluid & Nutrition, Tissue Viability and Falls. Attendance has been variable.
		• There are currently no formal processes to review multidisciplinary staffing levels & skills mix (16.8)

	available to hospital staff. (16.3 & 16.4) • Fundamental of Care Assurance tool has been implemented to provide leadership and support to the SCN and their Teams to improve care principles in the clinical setting. Mock Inspections by senior nurses identifies Staff and patient perspectives on the clinical environment are captured and nursing notes reviewed. The nurse in Charge is given immediate feedback and any areas of concern are actioned immediately. (16.2) • Rostering Guidance is available to staff and day-to-day dependency is assessed to ensure safe staffing levels are in place. (16.5) • Workload tools have been run in Adult inpatient areas, Paediatrics, Neonatal & Midwifery in 2018. A timeline for 2019 has been developed to run the tools within Community, Mental Health, and Emergency Medicine by the end of March 2019. (16.6) • Staffing level concerns are escalated through Clinical Nurse managers and placed on Safety Briefs for discussion at am and 2pm meetings. The Workload tools escalation process ensures the Associate Nurse Director reviews all recommendations (16.7) • Professional accountability for senior clinical decision making is developed through management supervision and the appraisal process (16.9)	