Borders NHS Board

Meeting Date: 4 February 2021

Approved by:	Nicky Berry, Director of Nursing, Midwifery & Operations
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CARE OF OLDER PEOPLE IN HOSPITALS UPDATE

Purpose of Report:

The purpose of this report is to brief the Board on activity relating to the Care of Older People in Hospital standards and to assure the board that activity to maintain and improve practice against the standards has continued prior to the pandemic and during the current exceptional circumstance.

Recommendations:

The Board is asked to **note** the report.

Approval Pathways:

This report has been prepared with the support of the Care of Older People in Hospital Steering Group to reflect the work of a range of clinicians and service managers across innumerable areas of clinical practice.

Executive Summary:

NHS Borders is committed to the delivery of safe, quality, affordable services which demand focus on maintaining a high quality of clinical care, the Healthcare Improvement Scotland Care of Older People in Hospital Standards (2015) are, in many areas, the clinical and care standards to which we will be held.

This is the third year I have presented a paper reflecting work on the COPH standards and, without a shred of complacency, I would note our direction of travel in relation to patient flow, intelligent and integrated management of a complex patient group is increasingly apparent in the aspirations and actions across the Older Persons Pathway.

Covid-19 has been the dominant influence on both community and hospital care throughout 2020 and has unfortunately stalled or delayed a number of key changes in service delivery. However NHS Borders can take justifiable pride in not only the way staff have responded to the demands of the global pandemic but despite that, the continuing focus on standards in other areas of practice.

It is to be noted that the dynamic situation within our inpatient services is such that a number of items cited in the paper reflective of ongoing work are in hiatus as a consequence of Covid-19 restrictions/

Examples of service development over the last year include:

- The establishment of twice daily BGH Integrated Huddles to review all complex discharges. These huddles bring together Senior Nurses, Social Work, AHPs and Operational Management to provide rapid multi-disciplinary problem solving to ensure timely transfer of care for predominantly older patients. This group has been a key factor in reducing the number of delayed discharges on the BGH site.

- The creation of an Older Person's Assessment Area in the Medical Admissions Unit at the start of the year – stalled after only two months at the start of the pandemic. This approach will be restarted when the Medical Admissions Unit steps down its Covid-19 assessment model.

- For winter 2020/21 the development of the Borders Urgent Care Centre which plans to centralise GP Acute Assessment referrals with GP capacity and a Minor Injuries service at the BGH. This should ensure more older patients are cared for in a scheduled service outside the busy Emergency Department environment.

- PACS are focussing on Older People's Pathways through a whole system approach reflecting recommendations from John Bolton's report to Scottish Borders in 2017/18. This seeks to improve patient flow, reduce care package prescription and access to appropriate services.

- Mental health services and community hospitals are, for the first time falling under the inspection regime against the COPH standards. Both boards are undertaking unannounced inspection in appropriate units to inform our oversight.

The majority of our in-patient beds are occupied by older people, this paper outlines areas of practice and areas in-development relating to the Care of Older People in Hospital Standards 2015 and seeks to assure the board that work in relation to the Older People's Pathway continues to ensure standards are maintained and quality is improved.

Impact of item/issues on:	
Strategic Context	Healthcare Improvement Scotland produce a range of clinical standards benchmarking healthcare delivery across Scotland. This report outlines NHS Borders position against the 16 Care of Older People in Hospital Standards 2015.
Patient Safety/Clinical Impact	This paper is intended to provide assurance that NHS Borders is meeting clinical standards, patient safety standards and delivering person centred care in these domains.
Staffing/Workforce	Workforce implications within this paper are addressed through the workstreams identified within it.
Finance/Resources	Financial implications within this paper are addressed in the projects and work streams identified.
Risk Implications	Risk implications are addressed through workstreams identified in the paper.
Equality and Diversity	The paper relates to the Care of Older People in Hospital, other aspects of EQI Assessments are addressed through workstreams identified in the paper.

Consultation	The paper has been developed in conjunction with a range of clinicians from a range of disciplines and reflects their work.
Glossary	Terms are explained throughout the paper as they arise.

Care of Older People in Hospital Standards Board update

October 2020

Peter Lerpiniere

Associate Director of Nursing for

Mental Health, Learning Disability and Older People

Healthcare Improvement Scotland
Care of Older People in Hospital Standards (2015)

Standard 1: Involving older people: "What and who matters to me"	
Standard 2: Maintaining patient dignity and privacy	
Standard 3: Decision-making, consent and capacity	
Standard 4: Initial assessment on admission to hospital	
Standard 5: Comprehensive geriatric assessment	
Standard 6: Pharmaceutical care	
Standard 7: Assessment and prevention of decline in cognition	
Standard 8: Delirium	
Standard 9: Dementia	
Standard 10: Depression	
Standard 11: Falls prevention management	
Standard 12: Rehabilitation	
Standard 13: Pre-discharge planning	
Standard 14: Care transitions	
Standard 15: Patient pathway and flow	
Standard 16: Skills mix and staffing levels	

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.	• The Adult Unitary Patient Record (AUPR), is now on version 19, most recent update is from August 2020. *(attached as appendix 1)* • Within the AUPR work continues to promote using care planning across all disciplines as standard. This follows a modifed Activities of Daily Living model (Roper, Logan & Tierney) • Throughout the first wave of Covid 19 the AUPR had to be slimmed down to allow for potentially faster admission and response. We have moved back to the previous documentation taking the learning from that experience into our next iteration. • Patient Passports for people with learning disability routinely accompany every patient with a learning disability on every admission. • AUPR includes communication deficits and aids in assessment and incorporates carers views. This is identified at the admitting ward, and is re-assessed on arrival(or as soon as possible after) to Department of Medicine for the Elderly (DME) ward to ensure that the initial assessment was correct. • Fundamentals of Care Audit Tool is used to monitor: o how patients are being spoken to o how they are supported o how they feel o Are they included in decisions about their care. Any actions required are entered into an action plan to be completed. *(Attached as appendix 2)* • 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 hospital where cognitively impaired. • Under normal circumstances our hospitals have open and accessible visiting arrangements But we are currently following guidance on visiting during Covid19 as directed by Scottish Government. • Part of that process is for the patient to identify their designated visitor and we work with that person to support care during that person's stay in hospital. • 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. http://intranet/microsites/index.asp?siteid=92&uid=41	• The AUPR is an iterative document. It will continue to require updating to reflect the changing care environment – as was evidenced during Covid19. does not currently record who the patient has consented to have involved in discussions about their care. • Getting To Know Me although completed as part of post diagnostic support and intended to be brought with patient when admitted to hospital does not come with the patient often enough when they come into hospital from home. • OPLS have access to EMIS to gain GTKM developed during PDS to support person centred care during admission and should be used to support care planning.

	• Information about what and who matters to the patient is discussed at length each week at the MDT. • Staff are being encouraged to implement the ReSPECT forms for patients to support discussions about the type of care people want.	
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) adaptations 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 continues to focus on the importance of making people feel welcome.
		• 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.
		• However, to comply with current social distancing requirements during Covid19 we are aiming to reduce bays to 4 beds affording more individual space within the bays.
		• 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 however ward 14 are trialling access to small quiet room where more sensitive conversations can take place or simply a very quiet area where people can be afforded a little peace.
		• Clinical governance currently reviewing the EiC, SPSP, BTB as one group of measures and QI workstreams
		• Personal Protective Communication (PPE) often acts as a barrier to person-centred communication as experienced by the patient. Staff work tirelessly and consciously to overcome that physical barrier using their emotional intelligence. (This is hard to quantify and measure but is good practice being undertaken across the board).

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	• The purpose of these standards is to ensure the right services are in place to support older people. • Introduction of the AUPR and ReSPECT support decision making and capacity. • New AUPR makes more explicit who the patient has consented to being	• Specialist Nurse in Liaison Psychiatry incorporating best practice into junior doctor induction session. Psychiatric liaison service is a workstream in the Mental Health transformation agenda and will

services, treatment or care on the grounds of cognitive impairment. 3.3 Patients (and/or representatives) are involved in all discussions and decision-making relating to their care and treatment, and healthcare records clearly document: a) who the patient has consented to being involved in discussions and decision-making b) who has been involved in the decision-making process c) what information has been provided to the patient (and/or representative) d) the treatment options and alternatives available to the patient, and e) the patient's decision. 3.4 The patient's capacity for decision-making relating to their care and treatment, is assessed, regularly reviewed and documented, where clinically indicated. 3.5 For patients assessed as not having capacity to make decisions, the principles of the Adults with Incapacity (Scotland) Act 2000 are applied as follows: a) patients are supported to express their opinion and make a decision as much as they are able to b) proxy decision-makers (for example, welfare attorneys) are consulted regarding the patient's proposed care and treatment, and c) the healthcare records document capacity assessment and contain copies of a Certificate of Incapacity and Power of Attorney orders.	involved in discussions and decision-making including identification of Power of Attorney – this will be a change in practice which requires continuous monitoring with new iterations of the AUPR. • Referral for Extra Contractual Referral is in no way age defined. • Ready access to Consultants in Geriatric Medicine ensure patients are not 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: o 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. o 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. o Information from the document is used to personalise care planning and provide specific information regarding the person's wishes. • Commitment 7: 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.	continue to support capacity assessment and equality of access to services for people with mental health problems. Appointment of Consultant in Liaison Psychiatry proactively supporting patient decision making. • Recording of discussions with relatives is inconsistent and discussion of Power of Attorney is not robustly pursued in all areas. • Consideration for testing AWI documentation and guidance in one booklet as implemented in NHS Fife.

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	• NHS Borders has ED Fractured Neck Of Femur pathway. • NHS Borders has a Fractured neck of Femur pathway. • New AUPR includes a comprehensive range of nursing assessment tools to ensure accurate assessment – including the HIS frailty screening tool which highlights patient who will benefit from Comprehensive Geriatric Assessment. • We aim to achieve 100% medicine reconciliation 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. • NHS Borders RAD Team (Rapid Assess and Discharge) work from the ”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 now a twice daily MAU board round where appropriate patients are identified for discharge, transfer to DME ward or community based rehabilitation. The morning board round is 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.	• The Home First (formerly Hospital 2 Home) team have increased the range of options on initial assessment with regards to admission avoidance and rehabilitation. • The development of the Community Hospital and Care Home Assessment Team within Mental Health increases the options of assessment and management of people with dementia specifically in community hospitals. • In 2018 Murray House, Kelso has opened and provides 18 specialist dementia care home placements. 7 of these beds are funded by the IJB for 5 years. • Consideration of increasing to 12 with a specialist dementia care panel to be developed • The liaison psychiatric service is being reviewed as part of mental health transformation agenda and will examine capacity to participate in assessment on admission within workstream. This work is in hiatus due to Covid-19 but remains in scope. • The Older Person’s Assessment Area (OPAA) was “up and running” for 2 months prior to Covid19. The model worked with this cohort of patients, focusing on enabling patients. We anticipate that we will return to this model post Covid. • The older adult pathway has identified 4 work streams which includes those discharged home to formal care. • The previously used Person Centred Care Tool is being revised to become supervision focused.

during an acute episode of care when there has been a change in the health status of the patient.		
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, H2H. • *Home First details embedded in Standard 12: Rehabilitation.* 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. Patients identified for transfer will be in DME beds within 24hrs. These are audited – although audit has been limited during C19. • AHPs working Sundays initiate their component of Comprehensive Geriatric Assessment. • Ortho geriatrics - Ward 9 have geriatrician input daily to initiate Comprehensive Geriatric Assessment. • Patients, where appropriate, admitted directly to ward 9 from ED. • Executive team have daily update on number of patients awaiting a bed in DME and how long they have been waiting. • 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 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. • Home First team now embedded as an important part of Older Persons Pathway.	• Continuous review of assessment practice to improve waiting times to DME & community hospitals. • Ongoing programme of work with involvement and engagement from health and social care colleagues to transform the Older Person's pathway. • Delivering the national and local approach is to care for people as close to home as possible and avoid hospital admissions which requires a shift in the balance of care for medicine of the elderly. • For winter 2020/21 the development of the Borders Urgent Care Centre which plans to centralise GP Acute Assessment referrals with GP capacity and a Minor Injuries service at the BGH. This should ensure more older patients are cared for in a scheduled service outside the busy Emergency Department environment. • The creation of an Older Person's Assessment Area in the Medical Admissions Unit at the start of the year – stalled after only two months at the start of the pandemic. This approach will be restarted when the Medical Admissions Unit steps down its Covid-19 assessment model. • MHOAS winter plan includes rapid assessment and support for people to avoid admissions to hospital.

	• The establishment of twice daily BGH Integrated Huddles to review all complex discharges. These huddles bring together Senior Nurses, Social Work, AHPs and Operational Management to provide rapid multi-disciplinary problem solving to ensure timely transfer of care for predominantly older patients. This group has been a key factor in reducing the number of delayed discharges on the BGH site.	
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 (Med Rec) 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. On transfer between care settings this information is provided via the Immediate Discharge Letter (IDL). The pharmacy team or nursing staff will confirm medication changes with the patient prior to discharge / transfer. Med Rec is completed by the MDT on admission and discharge – primarily by junior doctors, ANPs and pharmacists. Med Rec is also completed in the GP practices after discharge by the primary care pharmacy team. Medicines management reviews are carried out proactively by the pharmacy team prior to discharge. These assessments are recorded using a standardized assessment tool which is kept in the patient's notes. Patients are also referred to the pharmacy team for review by the MDT (including the social work team). Where required medicine management reviews are also carried out at Waverley, Garden View and in patients' own homes.  Medicines management screening tool feb 18.docx The 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 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 (specifically to the FY2s and GP trainees over the past year). For community hospitals, GPs will be implementing these guidelines but this is also supported by the DME consultants The pharmacy team provided an education session for the non-medical independent prescribers on polypharmacy reviews in relation to falls.	Medication changes are documented on the IDL which is given to all patients on discharge. The MDT continues to communicate with patients (and/or representatives) about medication changes and continue to improve on the documentation of these discussions. During Covid-19 the pharmacy team were minimizing contact with vulnerable patients therefore have been relying on nursing or medical staff to have these conversations with patients. Med Rec is no longer audited for the Scottish Patient Safety programme, but the pharmacy team continue to support Med Rec education sessions with the junior medical staff. Training continues for the ward based pharmacy technicians to complete medicine management assessments to support the proactive review of patients across all wards in the BGH. The pharmacy team is working with social work in developing questions for use on STRATA and OSAIC to provide a standardized approach in assessing patient nees for managing their medicines safely by "trusted assessors". 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 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.

	In last years report we proposed that we would begin auditing the anticholinergic burden for patients. An audit was completed in DME reviewing patients individual anticholinergic bundle (ACB) and assessing our practice of reducing this burden through our polypharmacy reviews. The audit showed we decreased the ACB in 37% of our patients, with a 48% reduction in the number of patients prescribed a medicine with a significant ACB score (scores of 2 or 3). ***Regrettably this work has been put on hold during Covid-19 but there are plans to re-implement this from November 2020***	
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 AUPR 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. • 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 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. • Cognitive decline is factored into decisions made around rehabilitation and informs referral to H2H. • Development of Community Hospital and Care Home Assessment Team will improve access and support for cognitive assessment in Community Hospitals. • Review of Psychiatric Liaison service will include assessment of cognition in older people. • Awareness and education of Think Frailty and Think Delirium toolkits is offered to clinical staff at Hosptial to home and the Community Hosptial. Consideration for nursing staff to complete and review 4AT.

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. • New AUPR includes 4AT as initial cognitive indicator as part of assessment on admission. • The TiME Bundle in delirium is included in new AUPR. • 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 • 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. • NHS Borders liaison nurse specialist and Consultant Psychologist operate delirium call back clinic. • A pathway has been developed for clinicians 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.	• Delirium screening is not embedded throughout none all areas of the BGH. • 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. • Awareness and education of Think Frailty and Think Delirium toolkits is offered to clinical staff at Hospital to home and the Community Hospital. Consideration for nursing staff to complete and review 4AT.

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.	• MWC for Scotland undertook themed visit to community hospitals. Dementia Nurse Consultant has developed action plan which was signed off by chief officer for health and social care. Please refer to current version of action plan which is reviewed every 3 months. Last reviewed August 2020 with 4 actions outstanding. *Recommendation 12 is unacheiveable and has been escalated to the MWC.* • People with a diagnosis of dementia on admission have this recorded in their notes as part of past medical history and current problems. • New AUPR includes 4AT as initial cognitive indicator as part of assessment on admission. • Current support and level of ability is recorded in admission documentation. • Nursing staff can access Mental Health background and care plans through EMIS if required. • Baseline cognitive assessment using 4AT is undertaken on admission. • Further assessment of cognitive function is made where clinically appropriate: o To inform capacity assessment o To support care planning o To support discharge planning o This should then be recorded in the patient's notes. • Few people 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. • 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. • There remains a keen uptake in the dementia champions programme an the next cohort of candidates has just been processed. NHS Borders has sent candidates to every cohort since the Dementia Champions programmes inception. 2 further cohorts have been funded through SG but on hold due to Covid-19.	• "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 . • Dementia Nurse Consultant undertaking "Walk in your shoes" following the experience of patients with dementia from admission to MAU through the hospital. • There has been little uptake in the attendance of stress and distress training by hospital staff across both the BGH and the Community Hospitals although the current action plan has shown an increase in attending the Informed about dementia training and since October 2018 all new staff achieve as part of the corporate induction. (either face to face or via Learnpro) • There are 20 dementia champions across BGH and community hospitals. There have been 3 network events with another planned in October 2019 in conjunction with NES to support leadership and being change agents in the ward areas. *(This was cancelled due to Covid and a Dementia Network will commence Spring 2021 to not exclude staff with an interest in dementia that are not a dementia champion.)* • Competing demand on Dementia Champions has led to limited success in their role and that some have changed roles and do not have capacity to continue as a DC. • To complement the dementia champions we have two staff who have completed the DSIL programme who have become part of the DC network locally. • June 2019 Scottish Government/Alzheimer Scotland published priorities and action plan for Dementia Nurse Consultants in Scotland and a local action plan is being developed at end of august 2019 with senior staff and to be reported through older people groups. • This report sets out a strategic plan and vision

	• The BGH 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.
	• 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.
		which outlines the main priorities, actions and Key Performance Indicators (KPIs) for the Alzheimer Scotland Dementia Nurse Consultant (ASDNC) group for the years 2019-20.
		• This is drawing on key achievements and impact areas from 2015-18 and in line with both Commitment 7 of the third National Dementia Strategy (2017-2020) and the 10 Dementia Care Actions in hospital care. The report does not focus on local priorities for individual ASDNCs - these will be set as local needs dictate. The priorities identified here reflect the central funding (approx 33%) from Alzheimer Scotland and Scottish Government and what the ASDNCs will realistically aspire to deliver in 2019-20.
		• Dates and responsibilities are not included (but all are proposed to be completed by the end of 2020). A detailed action plan, with dates, will be developed alongside the report by the ASDNCs and regularly reviewed.
		 
		Nurse Consultant report_FINAL.pdf
		• Community Hospital & Care Home Assessment Team is now working with community hospitals to support people with dementia.
		  • Psychiatric liaison service is a workstream in the Mental Health transformation agenda and will continue to support capacity assessment and equality of access to services for people with mental health problems.
		  • Strategy 4 was due for consultation April 2020 although on hold due to covid-19, although SG currently devising a recovery plan in the interim.

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: o Consultant Psychiatrist. o Specialist Nurse in Liaison Psychiatry in Borders General Hospital. • The Community Hospital and Care Home Assessment Team who support people with depression in 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 is an ongoing 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 remain a high number of referrals where greater ward interaction could be the solution but Psychiatry seems an 'easy alternative'. • It remains highly uncommon for consent to be sought, 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. The Suicide Prevention Action Plan supports Workforce development plans including suicidality training. • Psychiatric liaison service is a workstream in the Mental Health transformation agenda and will continue to support capacity assessment and equality of access to services for people with mental health problems.
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)	• Back to Basics – Forward to Excellence programme continues to provide a focus for reduction in falls with harm. • Falls Microsite is up and running providing information and guidance for staff. • The "After a fall" guideline has been updated. • Clinical Improvement Facilitator conducting falls analysis where areas may have disproportionate number of falls. • Assessment of patients for risk of falls, and completion and review of the person centred falls bundle. • THE PERSON CENTRED FALLS BUNDLE – is designed to ensure we	• Using care plans to promote the realistic medicine approach to risk assessment and planned management. • Shared risk with patient/carer/family to reduce restrictions placed on patient (E.G. Reducing close observations.) • Although Medicine Reconciliation does not include the list of medications which contribute to falls. all areas have a laminated sheet of low, medium and

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.	engage with families/carers/partners etc to inform what care planning is required to reduce the risk of the patient falling. ○ A further redesign of the falls bundle is under way. • With approval from MH clinical governance committee, following QI project, introduction of adapted falls bundle linked with care plan in Melburn Lodge (Borders Specialist Dementia Unit) & Lindean, recognising the different needs of this patient group. • Working with ED to identify patients who present with falls if they're admitted early alert to wards to ensure they are in the right place at the right time. Placement of patients in ward near nurses station and/or cohorting for patients at risk. • Audit of equipment across acute site ensuring access and availability for appropriate patients. • Use of closer observation by nursing is important but only in certain groups of patients and not all falls risk this is tailored to patients who are identified as unable to maintain their own safety • Essential care after a fall guideline (available on line. http://intranet/resource.asp?uid=21178) • Review of falls timely through datix process- and Falls Review Tool (available online http://intranet/resource.asp?uid=35941). • Use of technology when appropriate for certain groups of patients eg Bed sensors used to alert staff when vulnerable people stand, while being mindful that 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. At time of writing there is a 2 week trial of technologyoptions across the BGH. • Utilisation of the falls pathway to consider (see attached doc, 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).	high risk meds. • *(See Standard 6:- anticholinergic burden audit – currently on hold C19)* • Work continues to standardize leaflets across pathway eg Up and About • 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. • Previous response to planning has been reactive – falls work now using a QI methodology approach. Testing with support from QI skilled and trained staff on request from SCN/CNM. • All falls from acute site and community hospitals are identified at the hospital wide safety huddle Monday to Friday 8.30am. • Ward level staff knowing their data- working with the SCN/CNM to understand their data and how this can be accessed and displayed. Using the Care Assurance Information Resource as part of the Excellence in Care work to review data over time with the view to using this at divisional clinical governance and quality meetings. This will influence early triggers for improvement as well as assurance. ○ Development of new SCN score cards underway. • *SCN owning PSST and applying the principles consistently, testing of revised version in acute setting in 2 wards using QI methodology. This work is ongoing and the CNM/SCN taking this forward. We are aiming for electronic version once full testing complete.* • There are a number of environmental issues- reducing clutter, ergonomics of toilets, bathroom, lighting, colours – Falls work will support environmental assessment aligning with dementia nurse's assessment as there are synergies. • Falls strategy group- wide stakeholders across all professions, partners, fire and rescue, SAS, care home managers and SBC- working on strategy for NHSB - is to be re-established

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	• Nursing, Medical and Allied health professionals are integral to the rehabilitation provision within BGH and of the 4 Community Hospitals. • PACs focusing on delivering against John Bolton's recommendations to improve flow, reduce care package prescription and to ensure patients accessing appropriate services. • Integrated work between Home First and SBCares to deliver accurately against care needs and developing Trusted Assessor model. • Core AHP services are delivered Monday to Friday with some additional front door capacity at weekend. • Patient rehabilitation continues 7 days a week within the wider MDT team working to agreed plans. • All iterations of the new Adult Unitary Patient Record have enhanced the use of care planning to promote a rehabilitation focus. • Elderly stroke patients remain either on the Stroke Ward or be transferred to their local Community Hospital for their rehabilitation. This has been challenged during Covid-19. • 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, care plan and discharge plans. • The wider team members are 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 Nutrition 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	• 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. Potential to review environmental space within DME wards in the context of planned reduction of beds including management of the challenges of Covid-19 and infection transmission management. • 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. o Home First offer discharge to assess & limited rehabilitation for a short period of time on return home. o 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. • Work is underway to support locality working and engagement with social care and third sector partners for people requiring less formal community support. • Significant work to streamline and develop the bed-based intermediate care model including community hospitals is under way.

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.	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. o 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 has 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". • 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. Pilot community models funded by the IJB are currently under review by Transformational Programme. Focus is on reducing bed capacity, prevention of admission, discharge to assess and greater access to re-ablement and rehabilitation closer to home. • Waverley Intermediate Care Project supports, short-term rehabilitation (maximum 6 week period) led by AHPs within a care home with a focus on returning home. • "Home First" Project provides re-ablement approach to patients in their own home. Additional occupational therapy and physiotherapy resource within Eildon/Central to focus on early supported discharge and prevention of a hospital admission	

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
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	• Integrated MDT Huddle takes place twice daily in MAU identifying options for supporting patients to move to next part of their care journey. • The opportunity to refer to Home First supports a wider range of options in planning discharge and facilitates potential early discharge. • Medical wards operate a multi-disciplinary approach to discharge planning. • The vast majority of older adults do have a written discharge plan in the Adult Unitary Patient Record - regularly audited 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 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 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 ○ 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	Day of Care Audit highlighted that: • Medical wards do take a multi-disciplinary approach to discharge planning • Each of the community hospitals are developing consistent 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 General Managers to implement agreed procedures and practices. • Where possible the management of risks includes anticipatory care planning and is considered in ReSPECT documentation. • 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 • DME wards hold once weekly large scale MDT meeting and twice daily Dynamic Daily Discharge in order to improve communication and promote more cohesive care. These are often supported by Clinical Nurse Manager where appropriate. • Where absence of capacity to make decisions inhibits the ability to plan discharge we work with social work partners to enact legislation (EG. Guardianship, Section 13ZA of the Social Work Act.). Work ongoing to streamline this process. ○ During the first wave of the Covid-19 pandemic Scottish Government prepared

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.	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. o Discharge letter informs GP. o Referral to MHOAS for Post-diagnostic support. o 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.	emergency legislation to facilitate the rapid discharge of people unable to consent due to a lack of capacity. The was never enacted as services worked intensively together to do this effectively – including in the Borders.
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	• Integrated MDT Huddle takes place twice daily in MAU identifying options for supporting patients to move to next part of their care journey. • These site daily 0830am and 1345 huddles 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 commence an assessment once consent from the adult or their legal proxy is obtained, this document is stored within the local authority's electronic recording systems. • Social work compli • ance 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 Adult 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. • Home First offering wider range of options for care transitions. • Opening of additional dementia specialist beds in Murray House in Kelso offers options for different care settings. Patient's referred to Murray House are assessed by their staff in hospital to facilitate smoother transition. • Integrated Specialist Dementia Panel being developed to review those on waiting list for commissoined SD beds at Murray House. Currently 7 although proposal for 12 being pursued . • Development of Community Hospital and Care Home Assessment Team from Mental Health will facilitate transitions in care for people with dementia. • Borders Dementia strategic Implemention group relaunched and now chaired by Brian Paris. • Winter planning includes MHOAS home treatment

hospital discharge are reviewed weekly.		for their patients to reduce risk of likely admissions to hospital.
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 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).	Boarding poses particular risks during Covid-19 and is therefore under even greater scrutiny than usual. The following bullet points reflect "normal times". • 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 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. • 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.	• In the last 12 months there has been a number of changes across the system which have impacted positively on our patient pathways both within the acute and community setting. • A programme continues to improve flow through the BGH and build resilience including: • Twice Daily Dynamic Discharge programme to strengthen ward processes that deliver flow • Site & Capacity team to manage flow • Continued development of ambulatory care pathways. • Strengthening of flow management processes within the hospital
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	• 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 – this programme is currently being redesigned to an online educational model. The aim is to support renewed staff and patient safety	• SCNs join senior leaders in mock inspections utilising the Fundamental of Care Assurance tool. • NHS Borders were implementing a programme of transformational practice development to develop a culture of person-centred practice for SCN's – this

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.
	requirements following the impact of the Covid-19 public health pandemic.
	• 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 action is taken on any areas of concern immediately this is currently suspended following the impact of Covid-19.
	• Training across the hospital estate on dementia care, mapped against the Promoting Excellence framework, with E-Learning available at Informed, Skilled and Enhanced practice levels.
	• Within the Dementia Skilled module awareness raising on dementia, delirium and depression.
	• Link nurses for key areas of practice.
	  ○ Falls
	  ○ Tissue Viability
	  ○ Food Fluid and Nutrition.
	  ○ Dementia Champions.
	• Continuing the commitment to QI training across NHS Borders with staff trained to use a QI approach through a number of national programmes .
	• Rostering Guidance is available to staff and day-to-day dependency is assessed to ensure safe staffing levels are in place. SCN's have requested and been given the authority to manage their own rosters.
	NHS Borders complies with HIS healthcare staffing programme, clear processes are in place to run workload tools, this programme suspended in March 2020 due Covid-19. Plan to restart in late October.
	Preparation remains under way for introduction of Safe-staffing legislation.
	• Staffing level concerns are escalated through Clinical Nurse Managers and placed on Safety Briefs for discussion at morning and afternoon meetings and consequent patient flow huddles providing real time assessment of staffing levels aligned to workload supporting redistribution of staff to mitigate any safety risks.
	• Workload tools highlight evidence of staffing levels against activity for wider stakeholders to explore whether current levels meet service need. Workload tool escalation process ensures the ADoN reviews all recommendations.
	• Professional accountability for senior clinical decision making is developed through management supervision and the appraisal process.
		has been suspended due to Covid-19.
		• Since March 2020, following the impact of Covid-19 all scheduled classroom clinical skills, resuscitation and practice education was discontinued to accommodate the pandemic response.
		• Reinstatement requires measures to support the safety of staff avoid any potential threat of the virus. Release of current venues to accommodate face to face teaching was explored however the 2m distancing negated any effective implementation.
		• Challenges in the current environment present the opportunity to move to an online model. While education programmes are being ebuilt, this also needs to be balanced with access to socially distanced PC's and a quiet place to study. Disadvantaged staff groups may have unreliable access, competition for access to technology and underdeveloped skills for online learning.