Comments regarding the draft standards for Care of Older People in Hospital

A key element of developing our standards is to distribute them for public consultation. Your views and comments are valuable to us. All the comments and suggestions we receive will remain confidential (processed in line with the Data Protection Act 1998) and will only be used to help develop our final standards for Care of Older People in Hospital.

Please return your completed form by email to: hcis.OP-AC@nhs.net or post the form to Jim Smith, Project Officer, Healthcare Improvement Scotland, Delta House, 50 West Nile Street, Glasgow G1 2NP.

The consultation closes on **Wednesday 17 December 2014**.

At the end of the consultation period, all comments (which will be anonymised) will be published, together with the working group's response, on the Healthcare Improvement Scotland website (www.healthcareimprovementscotland.org).

The final standards for Care of Older People in Hospital will be published in **March 2015,** with publication of the consultation report in **April 2015**.

We would particularly welcome comments on:

1. Relevance to safe, effective and person-centred care
2. Key points or areas that are not covered
3. Additional evidence or references that should be included.

Name of respondent	**Dr A.D. Dwarakanath FRCPE**
Organisation (if applicable)	**Royal College of Physicians of Edinburgh**
How did you hear about the draft standards?	**HIS**
Comments	
Standard 1	
Statement	The Royal College of Physicians of Edinburgh ("the College") would appreciate clarification on the definition of 'Older People'? Is this still the over 65s, and if so, is this still appropriate?
Rationale	
Criteria	Ideally, criteria should be measurable and it may be difficult to monitor progress against these particular criteria.
1.1	Yes- though this should apply to all NHS users, and would be

	exemplified by showing interest in a patient's personal circumstances and past history.
1.2	
1.3	Yes- though it will be a challenge to ensure this is demonstrable/ explicit
1.4	
1.5	The College agrees that no services or interventions for adults should be available solely on the basis of age. This applies to both over and under 65s.
1.6	Yes- however the College would appreciate more detail on how this could be facilitated.
Other	Should there be mention in this standard section of those patients with cognitive impairment?
Standard 2	
Statement	The College agrees this is reasonable – and should apply to all age groups. The addition of the word "key" would be helpful as a patient may not expect to be involved in every routine decision, for example, which particular simple antibiotic to advise.
Rationale	
Criteria	
2.1	
2.2	
2.3	
2.4	
2.5	
2.6	The College agrees in principle but the emphasis could be placed on key issues to ensure smart manageable documentation.
2.7	
2.8	
2.9	
2.10	
Other	
Standard 3	
Statement	An alternative to "maintained" would be 'maximised' – in all cases – how can health professionals and clinicians make this process more dignified, more private?
Rationale	
Criteria	
3.1	
3.2	The availability of appropriate equipment and the provision of single rooms are very important in terms of achieving this criterion.
Other	

Standard 4	
Statement	Perhaps there could be acknowledgment of the patients' views in this statement as to where the "right place" would be located.
Rationale	In the second paragraph – adverse outcomes also occur if patients are unnecessarily admitted to or kept in hospital. The definition of boarding and more information could be included in the rationale itself rather than a footnote. Boarding is a sign of a failing system that requires a joined up approach to admission prevention and robust discharge management.
Criteria	
4.1	Agree- additionally boarding policies should not have any criteria that directly or indirectly discriminate against older people, and patients boarded, when audited, should not be disproportionately older than those in the wards from which they were boarded.
4.2	
4.3	
4.4	
4.5	This is a very challenging criterion. The balancing of risk between the index patient and another patient not accessing the correct care, getting into a bed at the right time (another criterion), being under direct vision of nurses etc will be testing. If multi-disciplinary team (MDT) agreement is required, it should be noted that the MDT is only available in most settings for around 40 hours out of each 168 hour week.
Other	There is no mention of a partnership role in this standard – lack of home care and social care provision impacts on patient flow and should also be addressed.
Standard 5	
Statement	
Rationale	
Criteria	
5.1	
5.2	
5.3	
5.4	The College would appreciate more detail on the "role-specific mechanisms" mentioned in 5.4 (b)
5.5	
5.6	
5.7	
5.8	The College would appreciate more detail on which staff would

	receive training in quality improvement methodology.
Other	The discussion of staffing levels in this standard is very process-heavy and aspirational. It would benefit from specific reference to the absolute relationship between case mix, case numbers, skill mix and staff numbers.
Standard 6	
Statement	
Rationale	It would be helpful to include mention of sensory impairment here, which is a major barrier to communication and awareness of surroundings etc. **Information provided at the point of admission** Many older people are now admitted to acute hospitals on a frequent basis, occasionally unnecessarily, but usually with acute or subacute medical and/or functional decline. Many of these patients are already very well known to community and health and social services, with extensive domiciliary care provision. Despite this it is extraordinary for anything other than basic information to be provided to the hospital at the point or time of admission. Typically, a GP computer printout of medications and past medical history, sometimes accompanied with handwritten comments, will be provided, but there will be little or no provision of information about the patient's usual functional or cognitive status, their support, or the concerns of any care agencies involved. Much of this information is critical to the assessment and care of the patient. As a consequence, staff from both primary and secondary care can then spend a large amount of time pursuing information on the patient. There are in effect no standards for the provision of information at the point of admission, even in matters as important as medicines reconciliation, placing an unhelpful burden on staff across secondary care at the point of admission.
Criteria	
6.1	
6.2	
6.3	
6.4	
6.5	Agree- however as above, there should be a clear expectation that community services provide this information to secondary care at or shortly after the point of admission.
6.6	The College would appreciate clarification of this statement.

Other	
Standard 7	
Statement	
Rationale	
Criteria	
7.1	
7.2	
7.3	
7.4	
7.5	
7.6	
7.7	
Other	Additional attention should be given in the document relating to the prevention of subnutrition; dehydration and pressure sores in acute care.
Standard 8	
Statement	
Rationale	
Criteria	
8.1	
8.2	
8.3	
8.4	
Other	
Standard 9	
Statement	
Rationale	The College generally agrees with the rationale for this standard, however it should be noted that "*Person centred goal should be developed with families, friends and carers as equal partners*" is only appropriate with the consent of the patient. *"Older people often want, where possible, to have care delivered either at home or in a homely setting close to their home".* Not all older people wish for this, and many of the intermediate care facilities offered are neither closer to the patient's home than the hospital nor more "homely". Also there are concerns that patients receiving care in local authority 'intermediate care" facilities are means tested and charged for their use – but identical care in a hospital is free of charge. This is inequitable and should be addressed.
Criteria	
9.1	
9.2	
9.3	The College agrees with this criterion; however it should be noted that transition to a true seven day service has significant resource implications which have to be addressed before such change can

	be implemented.
9.4	
9.5	
9.6	
9.7	
9.8	
Other	There is correct emphasis in this standard on timely provision however the lack of specific targets/ timescales will make the standard hard to measure.
Standard 10	
Statement	The College agrees with the statement; however these standards should apply in all settings where patients with these types of care needs are cared for, including non-acute NHS or community based settings.
Rationale	
Criteria	
10.1	
10.2	
10.3	
10.4	
10.5	
10.6	
Other	
Standard 11	
Statement	Agree- however we would again welcome clarification on the definition of “older people”.
Rationale	It would be helpful to amend paragraph two to say “the individual’s glasses or hearing aids are available *and functioning*”.
Criteria	
11.1	
11.2	Agree- this very specific time standard stands out in the document, perhaps to align with the 4 hour emergency care standard. Hospitals would be assisted in meeting this target if the information detailed at Standard 6 – Rationale (above) were available at the point of admission.
11.3	
11.4	
Other	
Standard 12	
Statement	
Rationale	
Criteria	
12.1	

12.2	
12.3	
12.4	
12.5	
12.6	
Other	
Standard 13	
Statement	
Rationale	
Criteria	
13.1	It may be helpful to take into account that some patients with dementia have not been previously recognised or had the diagnosis confirmed.
13.2	
13.3	
Other	The College suggests reference is made to dementia specific carer support in this standard.
Standard 14	
Statement	
Rationale	The College suggests mentioning the prevalence of depression in older people admitted to hospital and the role of assessment tools for depression.
Criteria	
14.1	
14.2	
14.3	
14.4	
Other	
Standard 15	
Statement	
Rationale	The College agrees, however notes that the emphasis is on discharge planning. Admission to hospital is also a care transition and attention should be given to communication between health and social care professionals at this time.
Criteria	Again, the definition of “older people” is important here.
15.1	
15.2	
15.3	
15.4	This should happen more frequently- perhaps daily.
Other	It should be recognised that delays in discharge have significant implications for patient care and more robust management of delays should be introduced to ensure patients are in the care setting that is appropriate for their needs.

	Integration of health and social care should assist in this regard, however this is a significant issue which is still not addressed in practice.
Standard 16	
Statement	
Rationale	
Criteria	
16.1	
16.2	
16.3	
16.4	
16.5	
16.6	
Other	Services in the community should in-reach to support discharge and community services also have an important role in preventing readmission. These community services should have easy access to specialist services to provide a menu of alternatives to prevent readmission.

Additional comments
The College largely welcomes these well written and commendable standards. There are some significant financial implications which need to be considered to ensure that changes required to enable services to meet these standards do not adversely affect other equally important services which do not have similar standards to meet. As such a cost benefit analysis on the standards should be undertaken. Consideration should be given to applying these standards to patients with frailty and/or complex care needs who are under the age of 65, therefore helping to avoid inadvertent discrimination.