Chapter 5
High quality care for all

5.1 Key audiences

Primary care trusts:

- chief executives
- leads on quality/personalised care
- commissioners of services for older people
- commissioners of acute health services.

NHS trusts and NHS foundation trusts:

- chief executives
- clinical directorate management teams
- medical directors.

5.2 Key issues and concerns

Lord Darzi's report, *High Quality Care for All*,[20] sets out a vision in which high quality care is central to the NHS. Quality is defined in terms of safety, effectiveness and patient experience:

> *"High quality care is care where patients are in control, have effective access to treatment, are safe and where illnesses are not just treated, but prevented."* [21]

This is reemphasised by the *2010 – 2015 NHS Strategy, From Good to Great. Preventative,* People-centred, Productive.[22]

Achieving age equality in health and social care[23] recommended that:

> *"The Department [of Health] and the health and social care system ensure that work to prevent harm and waste and spread innovation within the system should be designed to help promote age equality and that measures to end age discrimination are implemented so that they improve quality and productivity." (Recommendation 20)*

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[20] *High Quality Care For All – NHS Next Stage Review Final Report*, *Lord Darzi,* Department of Health, 2008
[21] *High Quality Care For All – NHS Next Stage Review Final Report*, *Lord Darzi,* Department of Health, 2008
[22] *NHS 2010 – 2015: From Good to Great. Preventative, People-centred, Productive*, Department of Health, 2009
[23] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

There is some evidence that high quality care can be maintained in a time of financial constraint and that promoting quality can help reduce costs.[24] [25]

The *NHS Next Stage Review* promotes a *Quality Framework*, consisting of seven steps, that encourages NHS local organisations and others to:

- Bring clarity to quality
- Measure quality
- Publish quality performance
- Recognise and reward quality
- Raise standards
- Safeguard quality (through clinical leadership and empowered patients)
- Stay ahead.

In order to ensure high quality care for all, organisations will need to ensure that services are age appropriate and promote equality (including equality in terms of age). There are a number of areas which currently may give rise to concerns in this respect.

Clarifying quality

In order to achieve the goal of high quality care for all it is important to understand the aspects of quality and person-centred care that are important to older people. Surveys and reports of older people's views consistently find that the following issues most concern older people when receiving NHS care:

- personalised care (being treated as an individual)
- retaining control over their routine
- maintenance of privacy and dignity (including single sex accommodation)
- healthcare professionals who communicate with them and listen to them
- joined up care.

Measuring quality

Use of data on the quality of services for older people

There is a large amount of information collected about the quality of services for older people, although this does not always reflect the issues that are a priority for older people themselves. There is also a considerable amount of information available about how older people experience the quality of health services, but this

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[24] *Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers*, Øvretveit J, The Health Foundation, 2009
[25] *Can quality and productivity improve in a financially poorer NHS?* Crump B and Adil M, BMJ: 339:b4638, 2009

is not always analysed or used by primary care trusts and service providers to make the changes that would improve the experience, effectiveness of care and the safety of older people when using health services.

Older people are less likely to complain

Complaints are a useful source of data on the quality of services[26], but a Care Quality Commission survey of older people[27] found that that only 27 per cent of older people in one area felt that their complaints would be listened to. One of the reasons some people were reluctant to complain was the fear that this would affect the treatment that they or their relatives received.

Patient experience - older people's perspectives on quality

Lord Darzi states that patient experience "*can only be improved by analysing and understanding patient satisfaction with their own experiences*". [28]

Personalisation

Older people want to be treated as individuals and receive care that is tailored around their needs. They want to be offered treatment choices, backed up with information, and recognition of their preferences. Concerns have been expressed, however, that some of the high profile aspects of personalisation such as personal health budgets may not have been designed around the needs of older people and require detailed evaluation before being rolled out.[29]

Privacy, dignity and single sex accommodation

The following concerns undermine dignity and are not uncommon experiences for older people in hospital settings:[30] [31] [32]

- being addressed in an inappropriate manner
- neglect of patients' appearance and clothing
- exposure, lack of privacy in personal care, and mixed wards.

Being in single sex accommodation and having access to single sex bathing, washing and toilet facilities is one of the most important considerations for older patients in maintaining their privacy and dignity. Older people in general, and

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[26] *Seeing the person in the patient – the point of care review paper,* King's Fund, Goodrich J and Cornwell J, 2009
[27] *Good practice in services for older people,* Care Quality Commission www.cqc.org.uk/_db/_documents/Good_practice_in_services_for_older_people.pdf
[28] *High Quality Care for All – NHS Next Stage Review Final Report,* Lord Darzi, Department of Health, 2008
[29] *Waiting for Change: How the NHS is responding to the needs of older people,* Help the Aged/ Age Concern, 2009
[30] *Dignity in Care Practice Guide,* SCIE 2006 – 2009 www.scie.org.uk/publications/guides/guide15/index.asp
[31] *On our own terms - The challenge of assessing dignity in care*, Help the Aged/Picker Institute, 2008
[32] *Caring for Dignity - a national report on dignity in care for older people when in hospital,* Commission for Healthcare Audit and Inspection, 2007

women over the age of 65 in particular, are more likely to find mixing "*not at all acceptable*" compared to other age groups.[33]

The Care Quality Commission (CQC) Inpatient Survey indicated that 32 per cent of respondents 'mind' sharing a mixed sleeping area, and that among women, older people and some ethnic minorities this figure rises steeply.[34]

The 2006 survey of NHS inpatients reported that nearly 23 per cent of older respondents had shared a room or bay with patients of the opposite sex.[35]

Being placed in mixed sex accommodation is a common complaint received by the Healthcare Commission from older people.[36]

Communication

Older patients are those least likely to be critical of any particular hospital situation, so it is particularly worrying that these same patients are less likely than those in middle age and early old age to describe their hospital care as "*excellent*" and most likely to feel talked over "*as though they were not there*" by medical staff. [37]

Older patients in hospital may feel worthless, fearful or not in control of what happens, especially if they have impaired cognition, or communication difficulties.[38]

Valuing staff

Staff that feel valued generally provide higher quality care to their patients.[39] It is important that providers of care to elderly people ensure that staff feel valued and supported. Overall, less than a third of NHS staff are satisfied with the extent to which their trust values their work, although this has increased substantially since 2007.[40]

Seamless care

Joined up care is a priority for older people.[41] [42] [43] Older people, who are more likely to be users of both health and social care than younger people, are

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[33] *Privacy and Dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals,* Department of Health, 2007
[34] *Delivering same-sex accommodation: a progress report,* Department of Health, 2009
[35] *State of healthcare 2007*, Healthcare Commission, 2007
[36] *Caring for Dignity - a national report on dignity in care for older people when in hospital,* Commission for Healthcare Audit and Inspection, 2007
[37] *Ageism and age discrimination in secondary health care in the United Kingdom*, Centre for Policy on Ageing (CPA), October 2009
[38] *Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies*, Bridges J, Flatley M and Meyer J, International Journal of Nursing Studies Vol 47 January 2010, p89-107
[39] *Seeing the person in the patient – the point of care review paper*, King's Fund, Goodrich J and Cornwell J, 2009,
[40] *National NHS Staff Survey 2008 – Summary of key findings,* Care Quality Commission, 2009
[41] *Older People's definitions of quality services,* Qureshi H and Henwood M, Joseph Rowntree Foundation, 2000
[42] *Your Health Your Care, Your Say,* Opinion Leader Research, *2006,*
[43] *Waiting for Change: How the NHS is responding to the needs of older people,* Help the Aged/Age Concern, 2009

particularly vulnerable to falling through gaps when services are not sufficiently integrated.

Safer care for older people

The quality of technical care is often taken for granted by older patients, and good or bad experiences are described more in terms of how staff relate to patients.[44] There are, however, some particular concerns about the safety of NHS care which require attention to ensure the quality of care for older people is promoted.

Falls in hospital and other NHS settings

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. In an average 880 bed acute hospital there will be around 1,260 falls every year resulting in estimated costs of about £92,000 for an average acute trust.[45] Older people are more vulnerable to falls and those aged over 65 years occupy more than two thirds of hospital beds.

Older people often do not receive optimum care and preventative advice when they are admitted to hospital following a fall in the community.[46] Whilst it is important to prevent further falls in hospital, it is also important to ensure that older people are enabled to move around safely in order that they can get the best from rehabilitation programmes. Also see Chapter 12 Falls.

Medication safety

Medication safety incidents were the second largest group of patient safety incidents reported to the National Reporting and Learning Service (NRLS) in 2006. Elderly patients are particularly vulnerable to medication related incidents.[47] The number of medication incidents (most commonly wrong dose, omitted or delayed medicines or wrong medicine given) was disproportionately high in those aged 75 – 94 years. The most vulnerable group (apart from children aged 0- 4 years) is those aged 80 – 84 years.[48]

A number of factors contribute to making older people more vulnerable to medication errors, including:

- the way the body handles medicines changes as people get older, making older people more susceptible to harm from dosing errors
- choice of formulation may be important, particularly in older people with swallowing difficulties

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[44] *Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies,* Bridges J, Flatley M and Meyer J, International Journal of Nursing Studies Vol 47 January 2010, p89-107
[45] *Slips, trips and falls in hospital*, National Patient Safety Agency, 2007
[46] *National Audit of the Organisation of Services for Falls and Bone Health of Older People,* RCP and HQIP, 2009
[47] *Safety in doses: Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009
[48] *Safety in doses: Medication safety incidents in the NHS,* National Patient Safety Agency, 2007

- older people are more likely to have multiple conditions leading to confusing drug regimes.[49]

The Department of Health highlighted the following issues as being particularly relevant to medicines management in older people:

- many adverse reactions to medicines could be prevented
- some medicines are under-used
- medicines are sometimes not taken
- inequivalence in repeat prescription quantities causes wastage
- changes occur in medication after discharge from hospital
- there can be poor two-way communication between hospitals and primary care
- repeat prescribing systems need improvement
- dosage instructions on the medicine label are sometimes inadequate
- access to the surgery or pharmacy can be a problem
- carers' potential contribution and needs are often not addressed
- detailed medication review minimises unnecessary costs
- some long-term treatments can be successfully withdrawn.[50]

Hospital acquired infections

C. difficile infection is more common in older people. Over 8 in 10 cases occur in people over the age of 65. This is partly because older people are more commonly in hospital. Also, older people seem to be more prone to this infection and C. difficile infection is also more likely in people who have a weakened immune system or other underlying health problems.

Urinary tract infections are the second largest single group of healthcare associated infections in the UK and make up 20 percent of all hospital acquired infections.[51]

Pressure ulcers

Pressure ulcers are more likely in high risk groups such as the elderly, obese, malnourished and those with certain underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection

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[49] *Safety in doses: Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009

[50] *Medicines and Older People: Implementing medicines-related aspects of the NSF for Older People*, Department of Health, 2001

[51] *Trends in Rates of Healthcare Associated Infection in England 2004 to 2008*, National Audit Office (NAO), Health Protection Agency, 2009

and a two to four fold increase of risk of death in older people in intensive care units.[52]

Effectiveness of care for older people

Access to effective treatments

Effectiveness of care is about understanding success rates from different treatments for different conditions.[53] There is some evidence that older people do not get equal access to some treatments due to age-related assumptions about their ability to undergo a treatment or benefit from it.[54]

Nutrition

Malnutrition in older people is under-recognised and common. Age Concern has described the growing risk of older people being malnourished or their nutritional status getting worse during an admission to hospital.[55] Malnutrition is associated with poor recovery from illness and surgery.[56] Yet the National Institute for Health and Clinical Excellence (NICE) found that only about one-third of patients were screened for malnutrition on admission to hospital.[57]

A common complaint received by the Healthcare Commission from older people was that they were not given appropriate food or help with eating and drinking. The Commission underlined the need for commitment to nutrition by healthcare organisations.[58] Older people following a major illness, such as stroke, those with other co-morbidity and those with mental illness have a greater risk of poor nutritional status associated with worse outcomes.

Dual/Multi-discrimination concerns

Black and minority ethnic older people in hospital have similar views to older people as a whole on the important aspects of quality care, though they also identify the following as particular issues:[59] [60]

- Food – not just food preferences and nutrition, but also hospitals' difficulties in providing special diets

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[52] *Predictive factors of in-hospital mortality in older patients admitted to a medical intensive care unit,* Bo M, Massaia M et al, Journal of the American Geriatrics Society, 51 (4): 529-33, 2003
[53] *High Quality Care for All – NHS Next Stage Review Final Report*, Lord Darzi, Department of Health, 2008
[54] *Ageism and age discrimination in secondary health care in the United Kingdom*, CPA, October 2009
[55] *Hungry to Be Heard,* Age Concern England, 2006
[56] *Disease related malnutrition*, Stratton R et al, CABI Publishing, 2003
[57] *Nutritional Support for Adults: Oral Nutrition Support, Enteral Tube*, NICE and the National Collaborating Centre for Acute Care, 2006
[58] *Caring for Dignity - a national report on dignity in care for older people when in hospital,* Commission for Healthcare Audit and Inspection, 2007
[59] *Good Practice Guide*, Social Care Institute for Excellence (SCIE)
[60] *The health and social care experiences of black and minority ethnic older people*, Moriarty J, 2008, Race Equality Foundation

- Communication – made more difficult by the lack of interpreters and the apparent inability of staff to cope with 'ethnic' accents or forms of speech
- Staff insensitivity and racism – especially in relation to religious needs and coupled with the more common complaint about respectful forms of address
- They are also more likely to be concerned about a lack of seamless care.

Most gay (older) people want their sexuality to be taken into consideration by those providing services and they want to be treated with respect and equality.[61]

People with learning disabilities often experience poorer quality care.[62] [63] There is an increasing group of people with learning disabilities living into older age with complex health needs. Commissioners and services providers need to ensure that those providing services have a better understanding of the needs of people with learning disabilities and that the quality of the service for them is closely monitored and improved.

5.3 Drivers and policy imperatives

Measuring and reporting quality

The Department of Health published guidance on the framework for quality accounts early in 2010:

→ www.dh.gov.uk/qualityaccounts

From April 2010, all providers of acute, mental health, learning disability and ambulance services will be required to produce a quality account. Further work is underway to develop quality accounts for primary care and community services providers with the aim to bring these providers into the requirement by June 2011.

The Department of Health, Monitor, Care Quality Commission and NHS East of England have also developed a toolkit of useful guidance and case studies to help NHS providers prepare their quality accounts. You can access the toolkit at:

→ www.dh.gov.uk/qualityaccounts

The NHS Strategy for 2010 – 2015[64] states that patient and carer measures of quality will be included in Quality Accounts.

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[61] *Gay and Grey in Dorset, Lifting the Lid on Sexuality and Ageing*, Help and Care Development Ltd, 2007
[62] *Healthcare for All – Report of the Independent Inquiry into access to healthcare for people with learning disabilities,* Michael J, 2008
[63] *Death by indifference,* Mencap, 2007
[64] *NHS 2010 – 2015: From Good to Great. Preventative, People-centred, Productive,* Department of Health, 2009

Patient experience

Essence of Care was launched in February 2001 and was designed to support the measures to improve quality set out in *A First Class Service*. It is a tool to help practitioners take a patient-focused approach to sharing and comparing practice, thus identifying best practice and developing action plans to improve care. It contributes to clinical governance at local level. The *Essence of Care* benchmarks are used widely through local NHS organisations and are constantly revised.

The NHS Strategy for 2010 – 2015[65] states that particular attention is to be given to improving patient experience particularly in cancer, stroke and heart care (as well as maternity services). The Strategy also sets out an intention to increasingly link provider income with patient satisfaction with their care.

Personalisation

Standard Two of *the National Service Framework for Older P*eople[66] aimed to ensure that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.

Lord Darzi set out a vision for improving quality in the NHS in which the personalisation of services is central.[67] Personalisation means different things to different people but the following definition may be useful:

> *"Personalisation reinforces the idea the individual is best placed to know what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so. In this way services should respond to the individual instead of the person having to fit with the service*."[68]

One way in which it has been proposed that care could be personalised is through the use of personal health budgets which help people to get the services they need to achieve their health outcomes, by letting them take as much control over how money is spent on their care as is appropriate for them. It does not necessarily mean giving them the money itself. Personal health budgets could work in many ways, including:

- a notional budget held by the commissioner
- a budget managed on the individual's behalf by a third party
- and a cash payment to the individual (a 'healthcare direct payment').

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[65] *NHS 2010 – 2015: From Good to Great. Preventative, People-centred, Productive,* Department of Health, *2009*
[66] *National Service Framework for Older P*eople, Department of Health, 2001
[67] High Quality Care for All – NHS Next Stage Review Final Report, Lord Darzi, Department of Health, 2008
[68] Carr, 2008, *Personalisation – a rough guide*, Adult Services Report 20, Social Care Institute for Excellence

Primary care trusts already have extensive powers to offer personal health budgets, either as a notional budget or held by a third party. The Health Act 2009 permits piloting of healthcare direct payments, and these are currently underway.

The NHS Strategy for 2010 – 2015[69] reemphasises personalisation of care in terms of tailored provision, personalised care planning and a more personal approach to nursing, particularly for people with long-term conditions, in addition to personal health budgets.

Dignity

The *National Service Framework Next Steps* report[70] aimed to ensure that, within five years, all older people receiving care services will be treated with respect and dignity. The report acknowledges the need for wide-reaching culture change and zero tolerance of negative attitudes towards older people.

The government's carers' strategy *Carers at the heart of 21st-century families and communities*[71] states that "*carers should be treated with dignity and respect both as carers and as individuals in their own right*".

The *NHS Constitution* states that patients have the right to be treated "with dignity and respect, in accordance with your human rights."[72]

The 2010/11 operating framework required all providers of NHS care to publish a declaration before the end of March 2010 that they have virtually eliminated mixed sex accommodation, and have plans in place for continued delivery of this commitment.

→ www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_112180

Communication

The NHS Constitution states that patients have the right to "*be involved in discussions and decisions about your healthcare, and be given information to enable you to do this"*.[73]

Seamless care

Standard Three of the *National Service Framework for Older People*[74] aimed to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.

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[69] *NHS 2010 – 2015: From Good to Great. Preventative, People-centred, Productive,* Department of Health, 2009
[70] *National Service Framework Next Steps*, Department of Health, 2006
[71] *Carers at the heart of 21st-century families and communities*, Department of Health, 2008
[72] *The NHS Constitution*, Department of Health, 2009
[73] *The NHS Constitution*, Department of Health, Department of Health, 2009
[74] *National Service Framework for Older People*, Department of Health, 2001

Safety

The NHS Strategy for 2010 – 2015[75] sets some "safety challenges" particularly focusing on the reduction of C. difficile infection, venous thrombo-embolism (VTE) and pressure ulcers.

Effectiveness

Standard Four of the *National Service Framework for Older People*[76] aimed to ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

5.4 What good age-equal practice might look like

Measuring and publicising the quality of care for older people

Use of information

Analyse data sources by age to understand the concerns and experiences of older people using health services. This could include:

- national patient surveys
- Local Involvement Networks (LINks) surveys
- serious untoward incidents
- complaints.

Share this information with older people and other partners to see where and how improvements can be made.

Complaints

Older people may need encouragement and support to make complaints. The Department of Health guide to the new complaints procedure[77] provides advice on how to support complainants, including the use of Patient Advice and Liaison Services (PALS) and the Independent Complaints Advocacy Service (ICAS).

Local health organisations might ask themselves the following questions:

- Are complaints policies and procedures user-friendly and accessible?
- Are complaints dealt with early, and in a way that ensures progress is fully communicated?
- Are older people, their relatives and carers reassured that nothing bad will happen to them if they do complain?

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[75] *NHS 2010 – 2015: From Good to Great, Preventative, People-centred, Productive,* Department of Health, 2009
[76] *National Service Framework for Older People*, Department of Health, 2001
[77] *Listening, Responding, Improving – A guide to better customer care*, Department of Health, 2009

- Are PALS and ICAS services sensitive to the needs and concerns of older people?
- Is there evidence of audit, action and feedback from complaints?

Local NHS organisations might also want to consider how they can use the new NHS and social care complaints process to achieve rapid resolution of individual cases of potential discrimination as recommended by the Review report *Achieving age equality in health and social care* – a report to the Secretary of State for Health.[78] (Recommendation 18)

Improving patient experience

A focus on making improvements in the following areas would improve the quality of care for older people:[79]

- assistance to maintain personal hygiene
- eating and nutrition
- privacy
- communication
- pain
- autonomy
- personal care
- end of life care
- social inclusion.

The King's Fund *Point of Care Programme*[80] is conducting work on transforming patients' experience of care and has gathered resources and research reports to support this.

Dignity

Help the Aged provides a useful table outlining what should be measured to assess whether health and social care services support the dignity of older users.[81]

The *Dignity Challenge* sets out national expectations of what constitutes a service that respects dignity:

→ www.scie.org.uk/publications/guides/guide15/challenge/index.asp

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[78] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, October 2009
[79] *On our own terms - The challenge of assessing dignity in care*, Help the Aged/Picker Institute, 2008
[80] www.kingsfund.org.uk/research/projects/the_point_of_care/
[81] *On our own terms - The challenge of assessing dignity in care,* p8-9, Help the Aged/Picker Institute, 2008

The *SCIE Dignity in Care Practice Guide* (Social Care Institute for Excellence) has useful guidance, examples from practice and other resources designed to assist organisations to meet the Dignity Challenge which sets out what people can expect from a high quality service that respects dignity.

→ www.scie.org.uk/publications/guides/guide15/index.asp

In addition local health organisations can:

- Ensure that treating older people with respect is fundamental to training and induction for all staff (including domestic and support staff) and followed up by supervision and zero tolerance of negative attitudes towards older people. *Achieving age equality in health and social care*[82] recommended that local statutory organisations should build into their contracts with providers of training programmes (including third sector and private organisations) the need for an explicit focus on age equality that supports staff in providing high quality services to people of all ages. (Recommendation 16).
- Ensure that the service is person-centred and not service or task-oriented.
- Ensure that service users are asked how they would like to be addressed and that staff respect this.
- Work to ensure that mixed sex accommodation, and its impact, is minimized in hospital areas where older people are treated.
- Ensure there is access to good quality interpreting services. People should not have to rely on family members.[83]
- Develop better end of life care for older people. See Chapter 15 End of Life Care.
- Develop better services for people with dementia and their carers. See Chapter 14 Mental health including dementia.
- Support intergenerational community activities to tackle preconceived ideas and discrimination against older people.

The Royal College of Nursing (RCN) has a *Dignity Campaign* including a support network and useful resources:

→ www.rcn.org.uk/newsevents/campaigns/dignity

[82] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009
[83] *The health and social care experiences of black and minority ethnic older people*, Moriarty J, Race Equality Foundation, 2008

Communication

Staff who connect with older patients, recognise older people's individual identity and involve patients in shared decision-making consistently link to more positive experiences for patients.[84]

Tools, such as *Essence of Care* benchmarking factors, can be used to document how staff communicate with patients, what information has been given and to check that it is in a format people can understand.

Equipment can be used to facilitate communication with those who have difficulty hearing or speaking, such as Royal National Institute for the Deaf (RNID) listeners, speech amplifiers and small whiteboards.

Safety

To improve the safety of health care for older people it is important to focus on:

- preventing falls
- learning from, and reducing, medication incidents
- reducing hospital acquired infections including C. difficile and urinary tract infections
- preventing pressure ulcers.

Preventing falls

The NPSA report[85] has useful guidance on preventing falls in hospitals. Also see Chapter 12 Falls.

Learning from, and reducing, medication incidents

The NPSA recommend that incidents should be reviewed on an age-related basis to identify risks peculiar to older people.[86] The Agency also says that initiatives to help reduce medication incidents involving elderly patients should include:

- a review of local arrangements for managing medication-related therapy for patients with swallowing difficulties
- a review of processes associated with medication concordance and compliance in elderly patients, particularly the use of patients' own medicines and compliance aids.[87]

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[84] *Older people's and relatives' experiences in acute care settings: systematic review and synthesis of qualitative studies*, Bridges J, Flatley M and Meyer J, International Journal of Nursing Studies Vol 47 January 2010, p89-107
[85] *Patient Safety Observatory, 2007, Slips, trips and falls in hospital*, National Patient Safety Agency
[86] *Safety in doses – Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009
[87] *Safety in doses – Improving the use of medicines in the NHS,* National Patient Safety Agency, 2009

Reducing hospital acquired infections including C. difficile and urinary tract infections

Further guidance on reducing infection is likely following these issues being flagged in the NHS Strategy 2010 – 2015 and in the *High Impact Actions* report.[88]

Preventing pressure ulcers

Further guidance on reducing pressure ulcers is likely following this being flagged in the NHS Strategy 2010 – 2015 and in the *High Impact Actions* report.[89]

Effectiveness

In order to ensure that older people receive the most effective care it will be important to ensure that decisions on access to treatments for older people are based on good clinical evidence rather than age-related assumptions about treatments. Increasingly, the evidence base should include effectiveness of care and treatment from the perspective of older people. Older people should be involved in commissioning and monitoring services, ensuring that quality indicators and outcomes are relevant to older people.

Quality and productivity

NHS Evidence has a resource section on quality and productivity setting out examples of how to improve both quality and productivity. There are a number of examples relating to the care and treatment of older people:

→ www.library.nhs.uk/qualityandproductivity

Nutrition

The effectiveness of care is assisted and enhanced by ensuring good nutrition and hydration in hospital. There are many initiatives around the country aiming to improve the way that older people are provided food in hospitals. One is the red tray system for identifying patients who require assistance at mealtimes. Food served on a red tray provides an effective signal to staff without compromising the patient's dignity.

The system is being monitored and refined, but has been found helpful in promoting individual care and staying alert to changing nutritional requirements. Designating patients who receive a red tray is part of initial and continuing assessment, and a daily updated list of patients due to receive food on red trays can be included in shift handovers and provided for kitchen staff. A red tray is also a simple reminder to staff to check the patient's notes for guidance on any specific help or nutritional needs.

Other ways to improve the provision of food to older people include:

- protected mealtimes – avoiding routine clinical activities at mealtimes to enable a focus on the food and eating

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[88] *High Impact Actions for Nursing and Midwifery,* Department of Health et al, 2009
[89] *High Impact Actions for Nursing and Midwifery,* Department of Health et al, 2009

- using volunteers to assist at mealtimes on wards – socialising with patients and helping them to eat where required
- use of the *Malnutrition Universal Screening Tool* (MUST) and personalised dietary care plans.

5.5 Case studies of illustrative / good practice

Volunteers and Mealtimes project

United Bristol Healthcare NHS Trust

The Trust has introduced a range of initiatives to improve nutrition and dignity at mealtimes, including the *Volunteers and Mealtimes* project, established on one ward to provide more assistance to elderly patients. The project set out to recruit volunteers to make mealtimes on the ward a more social occasion.

Following its success, more mealtime volunteers were recruited, each one attending a multi-professional half-day programme of training. The hospital is considering extending the idea to other wards.

Further information
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Facilitating dignified communication

Ashford and St Peter's Hospitals NHS Trust

The trust's Communication Group looks at how the communication needs of patients can be met. Clinical care indicators monitor the fundamentals of care and the patient communication interview, undertaken by the Patients' Panel, highlights any areas of concern or best practice regarding communication.

The group has undertaken extensive work to address the communication needs of individuals, in particular those with communication difficulties, and is currently building up a supply of equipment within the trust to facilitate more effective and dignified communication. These include Royal National Institute for the Deaf (RNID) crystal loop listeners, wipe-clean A4 boards and speech amplifiers.

Further information
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Nutrition

Accrington Victoria Hospital

At Accrington Victoria Hospital, every patient in the intermediate care stroke rehabilitation ward has an assessment of nutritional status on admission. The *Malnutrition Universal Screening Tool* (MUST)and a comprehensive multi-disciplinary assessment help to categorise patients into low, medium or high risk of malnutrition and to develop individualised dietary care plans.

Regular assessments and reviews are performed through multi-disciplinary evaluation and with the involvement of the patient and relatives, nutritional support is considered and given in the form of oral liquid nutrition, oral dietary supplements or intravenous or naso-gastric/peg administration where indicated. The choice of meals from patient of black and minority, ethnic (BME) communities includes both an acceptable vegetarian and halal meat diet (significant Muslim population).

In addition, personalised dietary care plans are based on choice of meals with due regard to religious and cultural backgrounds. People with dementia and those with severe disabilities from a physical illness such as a stroke, require help with feeding and this is achieved by awareness training, education and time for ward staff. An audit of nutrition in the elderly followed by a re-audit of patients admitted to the ward has helped to identify best practice.

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Implementing Dignity in Care

Luton and Bedfordshire NHS Trust

The Dignity Champion set up training and workshops and a pilot scheme took place on three wards. The implementation of the Dignity in Care initiatives spread to everyday practices via the establishment of a dozen Dignity Champions in the trust and at least one Dignity Lead on each ward.

When the Champions first met to discuss their role, they each made a pledge. This was followed up at each subsequent meeting to assess progress. The effects of good practice have spread with the result that gender separation exists on wards, 16 dignity pledges are being followed through by the Dignity Champions, a new quiet room has been set up for patients and relatives and a faith room has also been introduced.

(Source: Opinion Leader, *Dignity in Care Campaign Case Studies*, Nov 2009 p14, Department of Health)

Dignity in toileting

University Hospital of North Staffordshire, Stoke-on-Trent

The Dignity Champion, a matron at the University Hospital of North Staffordshire, found there was a general acceptance of the use of commodes amongst patients and staff in wards for older people. She was of the opinion that commodes are the most undignified pieces of equipment available to hospital staff yet they are commonly used for transport in addition to toileting.

On taking on her ward in 2008, one of the Dignity Champion's main aims was to reduce the number of commodes in use. She has succeeded in this at the same time as encouraging staff to take patients to the toilet if they are able to walk there, or transporting them on the new ARJO Steadys, a type of lightweight mobile chair, rather than toileting by the bedside which is now the exception rather than the rule.

Staff are now accustomed to transporting patients in the ARJO Steadys and patients are more than willing to use them. They generally only need one member of staff per patient unlike commodes that require two.

The Dignity Champion was successful in obtaining funding for additional ARJO Steadys on her four wards. She now has two per ward and plans for more. They are easy to use and to keep clean and hygienic. Patients and staff alike are in favour of the great improvement in dignity and privacy on the wards as a result of the use of the new equipment. The Dignity Champion has discussed this improvement with a consultative group that she meets on a regular basis, the Newcastle 50+ Forum, and they too have applauded the enhanced patient care.

(Source: Opinion Leader, *Dignity in Care Campaign Case Studies*, Nov 2009 p14, Department of Health)

Preventing falls in York

York NHS Trust

York NHS Trust conducted one of the largest studies of multifaceted interventions to prevent falls in hospital in six elderly medicine wards and two community hospitals, to achieve a significant reduction in the number of falls. The aim was to change the perception that falls are normal.

The study involved staff routinely looking for reversible risk factors for falls, and doing something about them. Assessments were made as straightforward as possible. For example, staff would stand at the end of the bed and hold up a pen and ask the patient: “What am I holding?” This indicated if there were any major eyesight problems.

The care plan gave the names of types of medication that might cause falls, so checking for them was easier. Urine was tested on the ward to find possible urinary tract infections, which could affect mobility and cause confusion. Blood pressure was checked with the patient both lying down and standing up. There was a yellow sticker to put inside patients’ notes that alerted doctors if a patient had fallen.

Inappropriate footwear was a big problem: many patients were wearing loose or ‘sloppy’ slippers, some had very unsafe footwear, or slippers had become wet or soiled and patients had to rely on hospital-provided foam disposable slippers which tear and hang off the feet. The hospital secured a small budget to buy some properly fitting slippers, in a range of sizes, for giving to patients when there are no relatives able to bring suitable footwear in. A repeat audit found a big reduction in unsuitable footwear.

The physiotherapists had found that nurses tended to tidy the walking aids into one corner where the patients couldn’t reach them. Staff made sure that patients who could safely use a walking aid on their own had one labelled with their name and kept within easy reach.

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(Source: *Slips, trips and falls in hospital*, Patient Safety Observatory, 2007, National Patient Safety Agency)

Seeing yourself as an older person

This practice example is underpinned by the assertion that exploring one's own feelings and expectations about older age is an important component in being able to develop relationships with older people and challenge ageist attitudes. Using principles developed with student nurses, hospital nursing staff were asked to think about and then draw themselves, aged 80. Nurses were then invited to explain any aspects of their drawing to their colleagues.

Through this exercise similarities and differences in attitude around older age emerged, e.g. whether nurses drew themselves as being alone, with one other person or as part of a wider community. The physical characteristics of ageing were an obvious focus of the pictures.

A discussion ensued around carer attitudes and how ideas about capacity and need can be based on physical appearance rather than conversations with the older person themselves. Nurses commented on how the exercise was enjoyable and thought-provoking. Using this simple but powerful tool in a safe and facilitated place, ward nurses were able to examine their attitudes and ambivalences about ageing and how the care offered to older people is thus affected.

Further information
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(Source: *Picture this, using drawing to explore student nurses' perceptions of older age*, Roberts S, Hearn J and Holman C, Nursing Older People, July vol 5, p1418)

Connecting with older people in hospitals

Working in an acute environment with a high throughput of patients, multiple transfers for individual patients and a focus on time-based targets can militate against connection with older people. Nurses in practice were enabled to know and hold in mind the older people they are caring for through a supported practice by which nurses introduced themselves to patients at the beginning of the shift. Nurses were encouraged to enquire how patients were and if an older person was new to the ward, how they would like to be addressed. This "*simple*" connection was challenging to the practice of some nurses and stimulated discussions around priorities and time pressures. Ongoing support was necessary to facilitate working in a different way and provide an appreciative stance to these morning conversations.

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(Source: Best Practice for Older People in Acute Settings (BPOP): Guidance for Nurses, Bridges J, Flately M, Meyer J and Nicholson C*,* RCN Publishing Company/City University London, 2009)

5.6 Suggestions for quick wins / what you can do now

- Look at last year's Annual Health Survey results to analyse how older people are experiencing the quality of the service.
- Seek other local information about older people's experiences of using health services (for example from local voluntary organisations or LINks).
- Review complaints from older people (65+) over the past two years and report trends to the primary care trust board.
- Work with local older people to seek solutions on how to address their main concerns about quality of services.
- Appoint older people's/dignity champion to the board.
- Ensure that medication, and other patient safety incidents, are reviewed on an age-related basis, discussed in clinical governance meetings and trends reported to the board.

5.7 Useful resources

Best Practice for Older People in Acute Care Settings (BPOP)
Guidance for Nurses (2009) Written by Dr Jackie Bridges, Dr Mary Flatley, Professor Julienne Meyer and Dr Caroline Nicholson, City University London. Available as CD and booklet.

Dignity Champions *Toolkit for Action*

→ www.dhcarenetworks.org.uk/dignityincare/Topics/Browse/ToolkitForAction/

Privacy and dignity – A report by the Chief Nursing Officer into mixed sex accommodation in hospitals
Makes recommendations and practical suggestions for improving the situation with regard to mixed sex accommodation.

→ www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074548.pdf

Help the Aged/Picker Institute, 2008, On our own terms - The challenge of assessing dignity in care
Help the Aged provides a useful table (p8-9) outlining what should be measured to assess whether health and social care services support the dignity of older users.