British Geriatrics Society
Improving healthcare for older people

BGS

Effective healthcare for older people

Principles and Standards

Introduction

This paper sets out the BGS principles and standards of good health care for older people, with a particular focus on those living with frailty. Getting health care right for older people helps to ensure we get it right for everyone.

The BGS believes:

- Older people should be properly valued, listened to and treated with compassion, and have their dignity, beliefs, needs and privacy respected at all times
- All older people should have equal access to assessment, care and treatment regardless of age, gender, racial or ethnic background, religion, sexual orientation, beliefs, disabilities, marital or civil partnership status
- Older people should be safeguarded from harm due to abuse, exploitation or neglect
- Health care professionals should involve (but only with consent from the patient or in their best interests) the families, carers and representatives of older people in decisions about their care and treatment.

Nothing in this document is intended to detract from the principles that apply to older people as enshrined in human rights and equalities legislation, or the professional codes (General Medical Council's Good Medical Practice, Nursing and Midwifery Council Code of practice, Health Professions Council: Standards of conduct and performance).

Principles of health care for older people

The BGS promotes the following principles of health care for older people:

Effective, accessible and timely care

1 All older people are entitled to a diagnosis or an explanation when they experience symptoms or a change in function.

2 Frailty in older people must be recognised and supported by access to integrated specialist programmes which enable maintenance or regaining of independence and well-being. Risks to health, independence and well-being in older age should be identified and a response based on the priorities of the older person and their families and/or carers.

3 Older people living with frailty who are admitted to hospital should follow a pathway for Comprehensive Geriatrician Assessment (CGA), whether or not they are under the care of a Geriatrician. Further detail about CGA is available on the BGS website **www.bgs.org.uk**.

4 Before any decision is made for longer term support or permanent move to a care home, all older people are entitled to a period of recovery, rehabilitation or re-ablement to help them reach their optimum level of independence and confidence.

Autonomy, choice and person centred

5 It is the right of an older person to be fully involved in making informed choices regarding their care. This will mean providing individually tailored information, advice and support and then respecting autonomy by giving control over what care and how and where it is delivered.

6 In order to avoid rushed and potentially unwarranted decisions, the views of older people living with frailty should be routinely and proactively sought with regard to end-of-life care, cardiopulmonary resuscitation, assisted ventilation, artificial feeding and other potential issues, so that their wishes can be included and followed as part of their individualised care and support plan. Health professionals must be trained and prepared to do this sensitively with full regard for the emotional needs of a person and the family/carers.

In situations where the individual lacks capacity, the thoughts of their carers/ family should be sought by health professionals in order to formulate a best interest decision.

7 For there to be genuine choice, safe, effective and appropriate services must be available for older people both within and outside hospitals.

8 When undertaking service planning and development, the views of older people, patients and carers either individually or as part of focus groups must be sought throughout the process. Where available, information from patient advocacy groups should also be sought. Where this is not acted upon, there should be a full and clear explanation.

Safety and dignity

9 Providers of health and care services for older people (and those who commission and manage them) must ensure that all staff involved in caring for older people are trained in, and understand, their particular needs.

10 All staff involved in the care of older people must be given the time and resources to respond with compassion to the complexities and needs of frailty.

11 Clinical priorities must dictate pathways of care. No pathway should be delayed or changed by administrative processes. For example; prolonged hospital stays due to ward moves within hospitals due to bed pressures or to assessment and decisions about Continuing Health Care funding (in England and Wales), discharge delays awaiting restarts of community care packages; delays in accessing care in community settings due to negotiations about access to and funding of 'step up' or 'admission avoidance' care.

Standards of health care for older people

Introduction

This paper sets out the standards which the BGS believes are needed to underpin high quality health care for older people in acute, community, care home and specialist settings. Each section has a brief overview and reference is made to source material where standards are listed in greater detail.

Acute illness

These standards will ensure rapid access to specialist health care at a time of crisis, either in community settings or in an acute hospital setting. They aim to make sure that the acute issues of an older person with frailty are managed in the context of a process of Comprehensive Geriatric Assessment (CGA).

To achieve this requires that:

1 All acute units should have a clearly defined strategy and written operational policy for the delivery of acute care for older people.

2 Hospitals should appoint a lead clinician for acute care of older people.

3 A single access and referral point for community-based clinicians should be provided to ensure rapid advice, assessment or admission for an acutely ill older person.

4. Older people should have ready access to necessary investigations and specialist advice regardless of their underlying condition or comorbidities, and regardless of the specialty which is currently looking after them.

5 Older people who need it, especially those with frailty, must be managed through CGA regardless of their age

CGA is a process of care involving multi-professional, holistic assessment, goal setting, focussed intervention and review. In an acute setting it reduces mortality and improves independence. Proper provision of CGA will require:

a. Arrangements for rapid access to specialist opinion over a 7 day week at the front door of the hospital, and to support older people living with frailty who are in hospital no matter which specialty is primarily responsible for the individual's care. Consideration ought to be given to appointing a dedicated geriatrician embedded within Emergency Department/Acute Medical Unit focussing on older people living with frailty.

b. CGA necessarily includes therapy professionals and other members of a multi-disciplinary team and must include mental health team support and easy access to social services and intermediate care 7 days a week.

c. Rapid access to CGA is equally required by older people managed through ambulatory care or community care as an alternative to hospital admission – whether because of co-morbidity, illness severity or personal choice.

6 All medical and nursing staff in acute units must be trained appropriately in the assessment and care of older people and wards must be properly equipped and staffed for their needs. There should be regular mandatory training programmes for:
   i. Recognition and management of delirium
   ii. Falls prevention and post falls care
   iii. Behavioural and psychological problems in dementia
   iv. Management and promotion of continence in older people
   v. Management of mobility issues
   vi. Providing care at the end of life
7 Notes and discharge summaries should contain a jointly owned comprehensive problem list and action plan which has been discussed with and takes account of the views of the patient and their relatives (when relevant). These plans must be shared with the GP and community staff.
8 Advance and Anticipatory care plans, including emergency care plans, must be offered to patients, at risk of deterioration and or death, and their significant next of kin or their chosen representative. These plans must be shared with GP and community staff. Account must be taken of plans which already exist and which have been created prior to hospital admission.
9 Regular clinical governance/audit meetings across the acute units must be set up to encourage staff to share good practice in the treatment of older people and reflect on challenging cases.

Further detailed standards are available in:

- Conroy S., Cooper N 2012. Standards for Acute Care for Older People, British Geriatrics Society. **www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/44-gpgacutecare%20**.
- Wyrko Z., (2013) Geriatric Medicine, Royal College of Physicians Consultant physicians working with patients: The duties, responsibilities and practice of physicians in medicine, pp 119-125. Available at **www.rcplondon.ac.uk/sites/default/files/consultant_physicians_revised_5th_ed_full_text_final.pdf**.
- Quality Care for Older People with Urgent and Acute care needs – (the Silver Book) BGS 2012. Download from **www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf**.
- RCN/NICE for Nursing numbers.
- Delirium Toolkit Health Care Improvement Scotland 2014. **www.healthcareimprovementscotland.org/our_work/person-centred_care/opac_improvement_programme/delirium_toolkit.aspx Accessed 23rd March 2015**.
- Dignity Campaign BGS 2010. **www.bgs.org.uk/index.php/dignity2010 Accessed 25th July 2010**.
- Dignity and Continence. **www.bgs.org.uk/index.php/dignity2012 Accessed 25th July 2015**.

Community services

These standards aim to ensure that frailty is recognised and results in access to an integrated care system which supports comprehensive geriatric assessment and addresses the priorities of older people and their families.

To achieve this there will need to be:

1 Locally developed, integrated, pathways for the management of frailty and frailty syndromes which ensure access to specialist and holistic care. This applies equally to older people with mental health and physical health needs as well as those with solely physical health needs.
2 A single point of contact facilitating access to community services or management of a crisis at home with specialist input and diagnostics. Properly accessible programmes should require no more than one telephone call to reach support.
3 Local agreements about how Comprehensive Geriatric Assessment will be carried out for older people with frailty and how information will be shared between hospital and community settings.

Further detailed standards are available in:

- Fit for Frailty Best Practice Guidance for the Recognition and Management of frailty in Community and outpatient Settings. Parts 1 and 2 BGS 2014 and 2015.
- NHS England, (2014) Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. Available at **www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf**.
- NICE: Supporting People with Dementia and their Carers in health and social care Dementia and delirium guidance CG42 2006. **www.nice.org.uk/guidance/cg42/chapter/introduction**.
- NICE: Falls: Assessment and prevention of Falls in Older people CG142 2013. **www.nice.org.uk/guidance/cg161**.

Care home settings

Standards here are about ensuring that older people resident in care homes continue to have access to free healthcare when needed, including specialist care – i.e. as part of their long term provision and at point of crisis. This will also ensure that they have access to appropriate care and support planning including end of life care planning.

Further detailed standards are available in:

- Fit for Frailty Best Practice Guidance for the Recognition and Management of frailty in Community and outpatient Settings. Parts 1 and 2 BGS 2014 and 2015.
- BGS Commissioning Guidance for Care Homes- can be downloaded at **www.bgs.org.uk/campaigns/2013commissioning/Commissioning_2013.pdf**.
- NICE; Quality Standard for Mental Well Being of Older People in Care Homes. Available at **http://publications. nice.org.uk/mental wellbeing-of-older-people-in-care-homes-qs50**.

Specialist geriatric services

Most of this document is about the standards which older people should expect when meeting the health and care service at any point. In addition the BGS has some minimum expectations for specialist departments of geriatric medicine (or equivalent).

Specialist geriatric departments and their staff must:

1 Seek to assure themselves that the above-mentioned Principles and Standards are rigorously applied in the department.

2 Define a minimum standard of training for their staff in specialist skills relating to older people. The minimum standard should be derived through a multidisciplinary process and be regularly audited.

3 Ensure that aids to communication are readily available (eg hearing aid batteries, low vision aids) in all areas where older people are cared for and that staff know how to use them. This is to be audited at regular intervals.

4 Ensure that main focus of their work is the management of older people with frailty, and they support the management of such patients wherever they are in the hospital.

5 Ensure that the services they offer are truly responsive to the needs of older people with frailty. This is likely to include the definition of maximum waiting times for access to services (e.g. Out Patient clinics and reviews in Emergency Departments).

6 Ensure that their subspecialty service provision for those with greatest need is not delivered at the cost of the holistic generic service.

7 Demonstrate that they are developing services through learning from the experiences of others and sharing good practice through participation in relevant national andegional events.

8 Provide expertise and leadership for the provision of services in community settings where this does not exist separately.

9 Challenge poor practice including attitudes and behaviours towards older people and demonstrate regularly how they have done this.

10 Constantly assess and assure the quality (Effectiveness, Efficiency, Timeliness, Equitability, Safety and Person Centeredness – including dignity) of the services they provide.

BGS Clinical Quality Steering Group, September 2015