

Caring for Older People: A Nursing Priority

Integrating knowledge,
practice and values

*Report by the Nursing and
Midwifery Advisory Committee*

March 2001



snmac

Caring for Older People: A Nursing Priority

Integrating knowledge,
practice and values

*Report by the Nursing and
Midwifery Advisory Committee*

March 2001

The Standing Nursing and Midwifery Advisory Committee (SNMAC) is a Statutory Body which advises Health Ministers in England and Wales on the provision of nursing and midwifery services under the NHS Acts. Members are appointed by Ministers following nominations by professional bodies and include the Presidents of the Nursing and Midwifery Royal Colleges. Its secretariat is provided by the Department of Health.

Foreword

The Standing Nursing and Midwifery Advisory Committee acknowledges the significant contribution made by nurses caring for acutely ill older people in a range of settings. In undertaking this project, initiated in April 1999 by Baroness Hayman, the then Parliamentary Under Secretary of State for Health, SNMAC found major deficits in the standards of nursing care given to older patients in acute hospitals, with some of their most fundamental needs remaining unmet.

The reasons for this are complex and numerous however SNMAC identified a lack of clinical leadership, management and role modelling, inadequate training and preparation of nurses for working with older people and deficiencies in the physical environment and resources as obstacles to the delivery of high quality care. Education, organisation and skill mix issues all need to be looked at in a unique way when caring for older people.

The persistence of negative attitudes about nursing older patients and deficits in core nursing skills are of great concern. Too many nurses regard fundamental skills such as bathing, dressing and assisting patients with feeding as tasks that can be delegated to health care assistants, often without supervision. SNMAC believes this belies the complexity of nursing and that qualified nurses should continue to be involved in the delivery of essential care.

Examples of good practice were identified often in less than ideal environments where clinical leadership and role modelling by nurses overcame common obstacles to the delivery of high quality of care. Principles, standards and indicators of good practice have been produced as an addendum to this report to provide guidance and support to nurses. SNMAC hopes this document will be circulated widely to every acute care setting where older patients are nursed.

The NHS Plan and NSF for older People provide a real opportunity to revise the nursing care of older people radically. This SNMAC report highlights areas of practice, leadership and education that need attention.

We hope this report provides an impetus to change and that the nursing profession will seize this opportunity. Our challenge is to Nurse Executive Directors and to each nurse to make care of older people *a nursing priority*.

Sue Studdy
Chairman of Sub-Group

Tony Bell OBE
Chairman of SNMAC

Contents

Executive Summary	3
Chapter 1.	
Introduction	5
Chapter 2.	
Motivation for the Study	6
Chapter 3.	
Approach of the Study	8
Chapter 4.	
Context of Care	9
Demographic and social context	9
The policy framework	10
Chapter 5.	
Findings of the Study	12
5.1 Introduction	12
5.2 Nursing practice and standards of care	12
5.3 Leadership, management and role modelling	20
5.4 Education, training and recruitment	23
5.5 Organisational and environmental factors	29
Chapter 6.	
Summary and Conclusions	35
Chapter 7.	
Recommendations for Action	37
Appendix 1	
References	40
Appendix 2	
Membership of SNMAC and Committee Subgroup	43
Appendix 3	
Sounding Board Participants	45
Appendix 4	
Sounding Board Conferences	46
Appendix 5	
Visioning Exercise	48

Executive Summary

1. The Standing Nursing and Midwifery Advisory Committee (SNMAC) was asked to “advise on standards of care for older people and their carers during an acute phase of illness” in April 1999 by Lady Hayman, the Parliamentary Under Secretary for Health. The remit covers standards of care in all acute settings, including Outpatients, Accident and Emergency, Theatre, Day Surgery, Radiology, and Day Services, and is not restricted to Medical and Surgical specialties. This remit enabled SNMAC to set up a sub-committee to take evidence from stakeholders and experts in the field and to conduct a review of the literature. This work, along with recommendations for action, is summarised in this report.
2. Older patients and their carers are the least satisfied of all groups with the care that they receive from the NHS when they are acutely ill. A large critical literature has been amassed which shows that current standards of care often fail to preserve older people’s dignity, privacy, autonomy and independence.
3. Older patients often have complex health care needs. They may have more than one diagnosis, requiring treatment for chronic illness and disability as well as the acute episode that has brought them into hospital. Sensory impairments, dementia or other mental health problems may create barriers to communication. Poverty and a lack of social support may compound the difficulty of solving problems particularly around discharge planning.
4. Older people now comprise two thirds of all patients in acute settings. This is partly due to the demographic shift in the population and partly due to the lack of more appropriate settings for health and social care.
5. The nursing care of older people is highly skilled and physically and emotionally taxing. Many nurses feel that they work in conditions that create obstacles to high quality care. The physical setting often increases patients’ dependency and nurses are often frustrated by the lack of essential resources. The reality of nursing does not match the image portrayed in the media and in advertising campaigns, and the content of nursing education gives inadequate attention to the needs of older people. This discrepancy between nurses’ expectations and the reality of the work probably contributes to the problems of retaining staff in acute settings.
6. The *NHS Plan* (Department of Health 2000) sets out ethical principles for the treatment of older people. Ageism is unacceptable, and care must be provided in a way that enhances older people’s dignity, autonomy, independence and privacy. Nurses must attend not just to the acute symptoms, but to the needs of the whole person, particularly nutrition, tissue viability and the promotion of independent activity.
7. The care of older people is mainly deficient in fundamental aspects of nursing, failing far too often to meet their basic needs for food, fluid, rest, activity and elimination. Their psychological, mental health, and rehabilitation needs are often ignored. Tasks in these areas are often delegated to the junior staff or referred to specialists. Skilled senior nurses must be re-engaged in the fundamental skills of nursing to improve standards of care.
8. The career pathway for nurses in acute settings needs to be developed so that ward teams are provided with access to specialist knowledge and expertise, as well as leadership, management and role modelling. Gerontological nurse specialists, consultant nurses and ward leaders could be the building blocks for constructing a career pathway that will enable senior nurses to remain in clinical work.

9. Current educational provision for nurses in acute settings does not yet reflect the changing demography and health care needs of the population. Course curricula must be revised to ensure that much more attention is given to caring for older people, for example, to disability, rehabilitation, palliation, and the treatment of chronic illnesses, as well as the fundamental skills of nursing. Media portrayals of the profession, particularly in recruitment campaigns, need to reflect that the majority of patients requiring acute care are older people.

Chapter 1. Introduction

- 1.1** In April 1999, Baroness Hayman, the Parliamentary Under-Secretary of State for Health, asked the Standing Nursing and Midwifery Advisory Committee (SNMAC) to “*advise on standards of nursing care for older people and their carers during an acute phase of illness*”. The remit covered standards of care in all acute settings, including Outpatients, Accident and Emergency, Theatre, Day Surgery, Radiology, and Day Services, and has not been restricted to Medical and Surgical specialties. In undertaking the remit, SNMAC was asked to identify principles, standards and indicators of good nursing practice and to advise on the organisational, contextual and environmental factors that impact on the nursing care of older people. This report summarises the work of SNMAC in this area, beginning with an explanation of why the care of older patients was identified as a priority for the attention of the nursing profession at this time.
- 1.2** Over the last 30 years, a large critical literature has been compiled on the standards of care that are available to older people, in hospitals, nursing homes and the community (e.g. Norton *et al* 1962; 1975). Recent reports suggest that the care that older people experience is still not of a consistent level of quality and safety across the United Kingdom (Clinical Standards Advisory Group 1998; HAS 2000 1998; Davies *et al* 1999). While there are some examples of high quality care being delivered to older people, they are the exception, rather than the norm. The goal of ensuring high quality nursing care for all older people in the National Health Service remains elusive.

Chapter 2. Motivation for the Study

- 2.1** Older people are now admitted to hospitals more frequently and for longer periods than any other age group. The National Beds Inquiry showed that two thirds of hospital beds are now occupied by people over 65, half the recent growth in emergency admissions comes from the population over 75, and half of those admitted are suffering from “symptoms, signs and ill-defined conditions”. Older patients who are admitted to acute health care settings often present with complex needs. They may have more than one diagnosis or underlying chronic illness in addition to the acute illness that is the direct cause of their admission. Older patients may suffer from sensory impairments that make them less independent and/or from memory loss, dementia or other mental health problems, leading to difficulties in communication and self-expression. The process of transfer to a hospital may in itself be traumatic and contribute to a decline in functional status. In addition, older patients may be living alone with little support and it may not be clear whether they should return home or move to some other setting once the acute phase of illness has passed.
- 2.2** Older patients often require more intense, more skilled, and more specialised nursing care than younger adults who are less likely to present with the complex picture of physical, emotional and social problems just described. This complex set of needs means that older patients often need skilled help from many different professionals and their pathway through the system is likely to involve a number of agencies and services. In addition to direct care, nursing staff in acute settings play a very important role in contacting, communicating and co-ordinating care from all the various services that need to work together to ensure continuity of care.
- 2.3** A great deal of evidence now exists that older patients’ experience of care in acute settings is often less than ideal. The HAS 2000 (1998) report revealed that older patients and their relatives are less satisfied with care compared to patients in other age groups. More specifically, this report identified problems in communication between staff and patients, deficiencies in specific nursing skills, problems with the physical environment and lack of resources, including shortages of staff, food, linen and equipment. Specific clinical areas of difficulty identified included accident and emergency where older patients often experienced long delays in the process of assessment, treatment and transfer. Discharge planning was often hampered by the lack of appropriate facilities in the community.
- 2.4** Core nursing skills in which deficits have been identified include communication. Older patients and their families are often left with the feeling that they have been given inadequate information about their care. Some areas, such as nutrition or the management of incontinence, which used to be the province of qualified nursing staff, are now often seen as areas of specialist intervention. There is also widespread recognition that many nurses see some of the fundamental skills of nursing, such as continence care, skin integrity, bathing and helping patients to the toilet as tasks that can be delegated to junior or untrained staff. Concern has also been expressed about nurses’ attitudes towards working with older patients.
- 2.5** Part of the difficulty in raising standards of nursing care is due to the lack of resources and poor quality of the physical environment. Staff often lack the basics—linen, pillows, dressings and personal items—that make caring for patients possible. The physical setting, which was often designed for another era, makes privacy and independence very difficult to achieve. Shortage of staff and inadequate skill mix in the ward team leaves individuals feeling over worked and stressed by being unable to fulfil all the demands on their time. The nursing care of older patients is physically and emotionally taxing. It is also highly skilled and

staff need supervision, training and appraisal systems so that they can continue to develop their practice and feel that their work is recognised and supported.

2.6 **In summary,** older patients are the least satisfied with acute care of all age groups. The care they receive often fails to meet their most basic needs, for food, fluid, rest, activity and elimination, let alone meeting their psychological needs. Current standards of care do not foster older people's sense of independence and self-direction and their dignity and self respect is undermined. Nurses do not feel trained, supported or empowered to act as patient advocates and even within the profession, the nursing care of older people is seen as low status occupation.

2.7 SNMAC's work to produce a report on the nursing care of older people in the acute phase of illness was influenced by the knowledge that problems in this area are long-standing and seemingly intractable. While the issues have been recognised for several decades there has been little serious, concerted effort to improve standards. The next few months will see a new campaign to improve the care of older patients in the NHS that will result in fundamental changes in services provided. The publication of the National Service Framework will provide an opportunity for all partners in the care of older people to review and revise services so that they are better able to meet the needs of this important group.

Chapter 3. Approach of the Study

- 3.1** SNMAC set up a sub-group of members and co-opted nurses with expertise in gerontology nursing practice, education, management, commissioning, and research, to oversee the development of the study. A full list of SNMAC members and the membership of the nursing care of older people sub-group is given in Appendix 2. This report is the product of a year's work by the group supported by a research team, which included a review of the literature, consultation with users, carers and professionals, and discussions with SNMAC colleagues and the older people's sub-group. Collaborative links were forged with expert researchers in the field. A member of the research team responsible for "Dignity on the Ward: Promoting Excellence in Care" (Davies *et al* 1999) which was commissioned by Help the Aged and the Order of St John, was co-opted to the SNMAC sub-group.
- 3.2** A sounding board event was designed to ensure that major stakeholders could contribute to the study, particularly with regard to identifying:
- principles, standards and indicators;
 - barriers to change and levers for change.
- 3.3** Participants included user and carer representatives as well as members of a wide range of professional groups who could articulate perspectives on practice, education, research, commissioning and policy. Further details of the sounding board events are given in Appendix 4.
- 3.4** Towards the end of the work, a meeting of the sub-group was organised to clarify the values that underpin this work and to generate a collective vision of better care for older people in acute settings. Further details of the "visioning exercise" are given in Appendix 5.
- 3.5** The end products of SNMAC's work include a literature review, standards, principles and indicators and a set of recommendations, which, if implemented could have a significant and immediate impact on the quality of care provided to older people.

Chapter 4

Context of Care

4.1 Nursing care is shaped by the social, political and economic context in which it is provided. Some social characteristics that are relevant to the nursing care of older people include changes in the demographic distribution of the population; rising income inequality and poverty among the elderly, and age discrimination that may underlie or rationalise lower standards of care for elderly patients. Current government policy with its emphasis on quality, accountability and performance management is designed to address inequities in the provision of health care and to emphasise quality of care as the primary goal of the NHS.

DEMOGRAPHIC AND SOCIAL CONTEXT

4.2 People are living longer. The Office of Public Censuses and Surveys (1991) estimates that the average life span is increasing by 2 years per decade. Old age used to be defined as over 65, but now a large and growing proportion of the population is over 75, and the number of people over 85 has doubled since 1981. The population of older people is extremely heterogeneous and there is a great deal of debate in the academic literature about whether an increase in longevity means an extension of healthy active life or an extension of morbidity. The majority of those reaching old age are still in good health (Victor 1991), and it is clearly wrong to stereotype older people as infirm. However, health indicators based on functional ability or disability do show a positive relationship between increasing age and functional disability and use of health services (Joy *et al* 2000). A number of diseases, such as hypertension, stroke, ischaemic heart disease, some forms of cancer and bone diseases, are strongly associated with age. Dementia and Alzheimer's disease are more prevalent among older people with the rate doubling with each 5 year increase in age, from 3% at age 70, to 20% at 85 (Prince 1997). The association of age with a number of debilitating illnesses, which are, as yet, incurable, suggests that the demographic

changes in the population will increase the demand for NHS services. However, it is difficult to predict exactly how demographic changes will affect the demand for NHS services because age alone does not determine health status.

4.3 Historians have challenged the idea that older people enjoyed greater power and prestige in the past than they do today (Kertzer and Laslett 1995). However, there is some agreement that recent social changes, such as the extension of education, could have been detrimental to the status of older people in our society (Lloyd-Sherlock 2000). Although the majority of older people are more financially secure than they were in previous generations, poverty affects a significant section of the older population. This is particularly true among women who have often had no access to a job-related pension, and the amount of the state pension is a source of great concern to many groups representing the interests of older people. Black and minority ethnic populations are disproportionately likely to be poor in their old age. In addition, rising rates of divorce, separation and job mobility mean that many old people live alone. Poverty and loneliness are related in an important way to physical and mental illness.

4.4 Negative attitudes towards older people may, consciously or unconsciously, affect policy makers and professionals in the NHS. At the macro-level, questions have recently been raised about whether or not older people have the same access to services, such as diagnostic facilities, intensive care or surgical or medical interventions, as are made available by the NHS to the rest of the adult population. At the micro-level, positive attitudes that convey respect towards older people are an important determinant of the quality of the relationship between nurse and patient and an essential component of a therapeutic ward culture.

4.5 Attitudes towards older people affect the quality of life that they experience particularly

the extent to which they feel included or excluded from society. Feelings of exclusion and social isolation can be even more intense for members of different ethnic groups who have to contend with more than one type of discrimination. A recent report by the Office for National Statistics (2000) states that there are 250,000 over-60s from ethnic minority groups and this number is set to swell as these groups age. The report compares ethnic and white populations on a number of poverty indicators including quality of housing, such as overcrowding, lack of central heating, dampness and condensation, and home, car and phone ownership. On an index of multiple deprivation, the survey found 47% of Pakistani and Bangladeshi pensioners experience three or more types of disadvantage, compared to 42% of Black Caribbean's, 26% Irish, 19% white and 13% Indian. In the recent past, there have been a number of very high profile cases suggesting that major British institutions, such as the police force, are capable of "institutional racism." If it is true that racism is tolerated and in some cases institutionalised in our society, it is essential that we guard against negative attitudes towards minority populations in any part of the NHS.

4.6 **In summary,** the older population is sometimes portrayed as "demographic time-bomb" that will put even greater demands on health care systems such as the NHS. We challenge the idea that all old people, or even the majority, have greater health care needs than the rest of the population. Negative attitudes towards older people, which are common in this society, can be compounded by discrimination based on race, ethnicity, gender and socio-economic status. Poverty, loneliness and social isolation have been implicated in the aetiology of many physical and mental illness and are therefore of great concern to health professionals. The NHS was founded on the principle of equity and the current government has stressed that every adult, regardless of age, is entitled to the same high quality service from the NHS.

POLICY FRAMEWORK

4.7 *The NHS Plan* (Department of Health 2000), which is perhaps the most radical and far-reaching reform of the NHS since its inception in 1948, was presented to Parliament by Alan Milburn, Secretary of State for Health, in July 2000. Many of the reforms are specifically designed to improve standards of care for older people. The plan emphasises that older people are entitled to the same services and standards as other adults and that everyone has a right to "dignity, security and independence in old age." Ageism in any form is intolerable in the NHS. Principles underlying the reforms include:

- Promoting the autonomy, dignity and privacy of older people.
- Treating the person, not just the most acute symptoms, by taking account of the full needs of older people. This should include ensuring good nutrition, maintaining tissue viability and enabling the older person to remain as active as possible while in hospital.
- Making high quality palliative and supportive care available to those older people who need it.
- Ensuring good clinical practice, which recognises the complexities of caring for older people, for example, by promoting the good practice recommendations contained in the 1999 report of the National Confidential Enquiry into Peri-operative deaths, *Extremes of Age*.

4.8 The focus of the *NHS Plan* is on four elements of care to which older people attach high priority: high standards, access to services, promotion of independence and fairness in funding.

- 4.9 Early 2001, a *National Service Framework (NSF)* for the care of older people will be delivered. It will set out standards particularly in relation to services for patients with a stroke, injury as a result of falls, or mental health problems.
- 4.10 With regard to access, the Plan emphasises streamlining assessment procedures. A single assessment process will be introduced for health and social care by April 2002 from which protocols can be developed for local use. At the same time, older people and their carers will be involved in agreeing a personal care plan, which they will hold. This document will describe their current package of health and social care, their care co-ordinator, monitoring arrangements, and a list of essential contacts for rapid response at home and in emergencies. The *NHS Plan* announces the government's intention to explore the potential for nurse consultants and specialist nurses in caring for older people.
- 4.11 The *NHS Plan* also focuses on promoting independence. This will involve developing services to support older people at home, as well as introducing intermediate care beds, rapid response teams to prevent unnecessary admissions, and extending respite services for carers.
- 4.12 The government's strategy with regard to the nursing profession is also important in understanding the context in which change in the care of older people can occur. In *Making a Difference* the government acknowledges the important role that nurses play in the NHS and sets out a new vision and strategy for nursing, midwifery and health visiting. Components of the strategy include: recruiting more nurses, strengthening education and training, developing career structures, enhancing the quality of nurses' working lives, improving the quality of nursing practice, building leadership, modernising professional self-regulation, and introducing new ways of working.

Chapter 5. Findings of the Study

5.1 INTRODUCTION

5.1.1 In the course of its work, SNMAC considered evidence from the literature and from the sounding board and visioning events that described grave deficits in the standards of nursing care given to older patients in acute settings¹. It is not confined to Medical and Surgical specialties. Although this situation is undoubtedly multiply determined, SNMAC identified a lack of clinical leadership, management and role modelling, inadequate training and preparation of nurses for working with older people, and deficiencies in the physical environment and resources as obstacles to the delivery of high quality care.

5.1.2 The report focuses on four areas where immediate action is required:

- Nursing practice and standards of care
- Leadership, management and role modelling
- Education and training
- Organisations and environments

5.2 NURSING PRACTICE AND STANDARDS OF CARE

5.2.1 The nursing care of older people has long been recognised as a “Cinderella service.” The work is physically hard and emotionally taxing, forcing professionals to confront their own deep fears about ageing and eventual death. The care of older people is sometimes seen as requiring less knowledge, skill and technical expertise than many other nursing jobs. Consequently, when older patients are admitted to acute settings they may be seen as inappropriately placed, or, having recovered from an acute illness they may be seen as “blocking beds” if they cannot be

discharged home or to a rehabilitation setting. The irony is that most patients now admitted to acute wards are “old” and acute care needs to be seen as primarily involved in the care of older people who have complex health care needs requiring skilled nursing.

5.2.2 **Failures of care:** This study has brought together considerable evidence, from the literature and from the experience of SNMAC members, co-opted members and others invited to contribute their opinions, to support the conclusion that older patients receive inadequate care in acute settings.

Important findings from the literature about the nursing care of older people include:

- The failure to maintain patients’ dignity and individuality in both hospital and community settings with care described as “routinised” and “ritualised” (Reed and Bond 1991; Koch *et al* 1995; Waters and Luker 1996; Nolan 1998).
- The failure to understand and provide for the mental health needs of older patients and their carers (Kitwood 1997; Hunter 1997; Goldsmith 1996).
- The persistence of negative attitudes about nursing older patients which have been attributed to the focus on fundamental aspects of care and the importance of rehabilitation in the context of chronic, often multiple conditions (Davies *et al* 1999; Nolan *et al* 1997; Pursey and Luker 1995).
- The recognition that nursing education and training currently focuses on the acute care of young adults with single disease conditions who will return to

1 “Acute settings” is here being used in the wider sense to include outpatients, accident and emergency, theatre, day surgery, radiology and day services.

work and family life rather than on the care of older patients and their carers. This suggests that nursing education and training needs a radical overhaul to equip nurses to provide for the needs of older patients and their carers who are in fact the major users of acute services (Nolan *et al* 1997; Masterson 1997).

5.2.3 Taken together, these studies suggest that there are deficits in the core nursing skills required to meet the needs of older patients. Too many nurses see fundamental skills, such as bathing, helping patients to the toilet and assisting with feeding as tasks that can be delegated to junior or untrained staff. The emphasis on qualified staff being involved in patients' activities of daily living may have shifted as other aspects of the nursing role, such as technical and managerial components have developed. But skilled nursing care cannot be delivered from a distance or through agents. It is a "hands-on" activity. Qualified nurses must continue to be involved in the delivery of essential care to enable them to know the patient, assess their physical and mental state and develop a therapeutic relationship. When senior nurses are involved in fundamental aspects of care, deficiencies in care delivery can be detected and rectified at an early stage thus minimising the occurrence of adverse events.

5.2.4 **Fundamental nursing skills:** SNMAC argues that because of the changing demography of the population of patients in acute settings, more attention needs to be paid to equipping nurses specialising in adult acute care with fundamental knowledge and skills related to nursing older patients. These must include:

- The ageing process, including the concept of multiple pathologies and diseases of old age
- Understanding the impact of life transitions
- Recognising the contribution of biography to an older person's perspective on their health needs

- Nursing assessment and care planning including physical and psychological needs, mental health assessment and prioritisation of complex needs
- Communication with patients some of whom may have cognitive impairment and/or deficits in sight or hearing
- Encouraging participation and involvement of older people.
- Enabling patients to maintain their activities of daily living
- Identifying and meeting nutritional needs
- Management of incontinence and constipation
- Rehabilitation and mobilisation
- Medication management, including self-medication
- Maintenance of skin integrity including the prevention of pressure sores and the management of leg ulcers
- Management of dementia and confusional states, mental health and depression
- Discharge planning
- Knowledge of Health and Social Services, the network of facilities and systems to support older people with on-going health and social needs.

5.2.5 The nursing care of older patients may have been affected by the trend towards increasing specialisation in the health professions. In the past, any qualified nurse would have been expected to be able to assist with activities of daily living, including the management of incontinence, nutrition and skin integrity. However, this may not now be the case. Nurses may identify these areas as requiring specialist skills. Deficits in the skills and knowledge of

general nurses in these areas may be due, at least in part, to the lack of clarity over role boundaries. The rapid expansion of specialities within nursing and the developing role of the allied health professions, e.g. physiotherapy, occupational therapy and dietetics, mean that several separate professional groups are now responsible for aspects of care, such as nutrition, that were previously nursing domains. There is also a large and growing number of nursing specialities, such as tissue viability, continence and infection control, whose areas of expertise overlap with traditional nursing practice. Increasing specialisation may have had the unintended detrimental effect of de-skilling adult nurses. The number of specialisations seems likely to increase over time. It seems important therefore to recognise and develop the role that nurses have always played in co-ordinating the activities of the different professional groups that have input into any individual patient's care. The role boundaries and expectations of specialists and generalists also need to be clarified. As acute health care settings become increasingly complex and technologically sophisticated, the generalist skills of the nurse, their patient centred perspective, and their ability to co-ordinate and substitute for specialists when necessary, are becoming increasingly valuable.

5.2.6 **Focus on food:** Difficulties that patients experience in achieving or maintaining their nutritional status exemplify many of the problems described above. Good nutrition is central to health and healing which is the primary goal of nursing any patient in any setting. For some patients meals are one of the events that breaks up a long and boring day. For others, food is a vital part of their therapy. For example, blood glucose levels in the elderly tend to drop in the evening thus increasing disorientation and confusion. This could result in the unnecessary use of night sedation. Again, food is the means by which normal bowel function is restored, or long-standing problems, such as irritable bowel syndrome or diverticulitis, addressed. Older patients may have preferences and habits that do not fit well into patterns of institutional catering. They may

find regular small snacks more appealing than three large meals a day and may have tastes that differ from younger age groups. Patients and particularly their relatives are concerned about the shortage and poor quality of food and drink in acute settings. Some of the problems include:

- The rigidity and inflexibility of hospital routines, sometimes reinforced by health and safety regulations. Patients cannot store any food that needs refrigeration in the ward and unless staff are prepared to bend the rules, they cannot provide snacks for patients between meals. This means that if patients are hungry between meals, ward staff have to contact the kitchen to ask for food to be brought to the ward specifically. In practice, this is unlikely to happen and in most cases patients end up waiting until the next meal. Hospital wards used to have the facilities for preparing snacks, if not full meals. Patients now have to rely on the hospital kitchens which have to adhere to a rigid schedule and are limited in the extent to which they can meet patients individual needs, at least at current levels of funding.
- Food preferences are often related to age and cultural influences. Older people may prefer traditional British foods rather than the more cosmopolitan diet of younger age groups. Members of ethnic or religious minorities will also have food preferences that differ from the majority. It is essential that nurses assess patients' food preferences and try to adapt hospital menus and routines to meet the nutritional needs of individuals.
- Patients with dementia may "wander" and could find it difficult to sit long enough to eat a full meal. In this case, they may appreciate being provided with finger foods which they can consume as they walk around.
- Ill patients often need help to maintain an adequate intake of food and fluid. This

may range from simply making sure that the patient can reach their meal, through encouraging the person to eat, to physically feeding someone who is unable to do this for themselves. Although dieticians have an important role to play in promoting the nutritional status of patients, ensuring that each patient has an adequate daily intake of food and fluid is a nursing responsibility. Meeting this goal is not easy. It requires a

great deal of nursing skill to assess the level of help that each patient requires to maintain a good intake and it requires sufficient staff on the ward to ensure that each patient has the help that they need. There may not always be someone present to help patients who need physical assistance to eat and drink. Feeding a patient takes dedicated individual time and skill that is borne of education, training and practice.

Developing a strategic approach to nutritional care management

Led by the Director of Quality, St George's Hospital, London, has established a multidisciplinary Nutrition Strategy Committee, with the following terms of reference:

- To bring together managers and professionals involved in the provision of 'normal' food and nutrition support within the Trust
- To advise through the existing Medical Advisory Committee, the Medical Director and Chief Executive on matters relevant to nutritional practice and policy
- To manage a Nutrition Support Team and co-ordinate nutritional support services throughout the Trust
- To produce guidelines for the universal nutrition assessment of hospital patients for appropriate nutritional management and referral to the Nutrition Support Team. To advise on the purchase of suitable products relevant to dietetic therapy and nutritional support
- To develop a strategy for improving the nutritional education of health professionals
- To agree clinical standards for structure, process and outcome in the provision of nutritional care which may be applied to audit and the contracting process
- To liaise with individual specialities through the existing Service Delivery Unit structure. Where necessary to co-opt additional members by agreement with the Medical Advisory Committee
- To review expenditure on catering and nutritional support in order to improve cost-effectiveness and quality.

Membership of the Committee comprises: Manager, Dietetic Services; Pharmaceutical Manager; Director of Nursing; Estates Director; Director of Quality; Business Manager; Faculty of Healthcare Sciences representative; Health Promotion Hospital Co-ordinator; Consultant Clinician

The Committee's main achievement to date has been to complete a comprehensive audit of the Trust's food services based on *Nutritional Guidelines for Hospital Catering* (DOH 1995) and to develop an Action Plan.

Maryon-Davis and Bristow (1999)

5.2.7 Nutritional problems in hospital cannot be solved by uni-disciplinary interventions. Many different professional groups and services in acute settings need to work together to improve the diet that patients receive. The NHS plan promises that more money will be made available to deliver improvements in hospital food. The above example illustrates the kind of strategic, multi-disciplinary concerted action that is required to ensure that additional funds are used wisely.

Assessment

5.2.8 Assessment is the key to providing services that meet individual needs and allow for patient participation and choice. Nursing assessment in particular has been criticised as missing the individuality or spirituality of the person. Assessment processes need to be based on an evolving professional relationship in order that the process of gathering relevant information is not experienced as intrusive. The assessment of health and social care needs of older people prior to surgery should be explicit in the pre-operative screening process to expedite discharge and ensure needs are planned for and met. The depth of an assessment needs to be negotiated with the individual and the importance of involving families in the assessment process cannot be sufficiently stressed. Assessment needs to be seen as a continuous process. Biography can be seen as a useful component of the assessment process and more research should be done to explore its contribution to patient care. Many practitioners find that one of the most useful texts is "A Systematic Guide to the Nursing Process" published by the Open University. Particular attention needs to be paid to the mental health needs of older patients. Older patients often (35%) present with a co-morbidity of physical and mental problems, most commonly dementia and depression. Yet the psychological need of patients are often badly neglected. Central Manchester NHS Trust has produced a first level assessment tool for adult nurses to use with all patients over the age of 65 years combined with core care plans for the management of depression and dementia.

5.2.9 Ideally the approach to assessment and care planning should be holistic and multi-disciplinary, yet there is no inter-professional consensus about what constitutes good practice in the assessment of older people. All too often, each discipline conducts their own assessment on which a uni-disciplinary care plan is based, which may not even be shared with the other professions involved. This is recognised in the NHS Plan, which states that by April 2002, a single assessment process for health and social care, with locally agreed protocols, will be introduced. An assessment framework will be part of the NSF for older people. During the same year, older people and, where appropriate, their carers, will be involved in agreeing a personal care plan, describing their current package of health and social care, and identifying their care co-ordinator and monitoring arrangements. A list of key contacts for rapid response in emergencies will be included in this document which the patient themselves will hold.

Factors conducive to high standards of care.

5.2.10 Research sponsored by Help the Aged and the Orders of St John Trust entitled *Dignity on the Ward: Promoting Excellence in Care* argued that standards of care depend on adequate staffing, leadership and co-ordination of different services (Davies *et al* 1999). The quality of care can be improved when ward teams work together to create a caring culture that values older people, their families and the staff working with them. Four principles underpinning good practice were identified:

- **valuing fundamental practice** - which means giving priority to the essential needs of older people such as help with personal hygiene, nutrition and going to the toilet and involving senior staff in delivering care
- **fostering stability while embracing challenge** - creating a stable ward team and a working environment in which innovation is valued and promoted

- **establishing clear and equitable therapeutic goals** - ensuring that older people have the same access to services as younger people, that clear treatment goals are set in conjunction with older people and family carers and that these are regularly reviewed
- **commitment to an explicit and shared set of values** - developing an agreed philosophy of care which clearly identifies standards of care and support expected for both older people and staff

5.2.11 *Dignity on the Ward: Promoting Excellence in Care* also identified ten challenges to improving the care experience for older people. These were:

- ensuring continuity of care across health care settings
- involving older people and their families
- involving local communities
- meeting the needs of older people with confusion or dementia
- meeting the needs of older people from ethnic minorities
- helping people to come to terms with death on the ward
- attending to small details that help maintain an individual's dignity
- demonstrating commitment to developing practice
- developing specialist roles
- managing change effectively.

Recognising these challenges can be the first step in devising local strategies to ensure the co-operation of nurses, doctors, managers and allied health professions to ensure that each challenge is met.

5.2.12 Action research and practice development are emerging as important ways of improving services. Both methods of social change need further evaluation to establish their effectiveness.

Standards of care for older people

5.2.13 Principles, standards and indicators of good practice have been devised from the literature. These were reviewed and revised at the sounding board event to ensure that they will meet the needs of users, carers and professionals.

5.2.14 The standards document describes a number of expectations about the minimum standards of care that older people should receive in acute settings. The full document, which gives the principles behind the standard, the standard statement, criteria by which the attainment of the standard might be appraised and a number of indications for each criteria, is published as an addendum to this report. Below we summarise the principles on which SNMAC standards are based and list the clinical areas for which specific standards exist.

- Respect for, and maintenance of, older persons dignity
- Promotion of choice, involvement and independence of older people and carers
- Facilitation of communication with older people and their carers
- Individualised care and its management

Principle standards and indicators were also identified for a number of clinical aspects:

- Continence
- Dementia
- Mental health
- Mobility

- Nutrition and hydration
- Pain management
- Palliative care
- Pressure damage prevention and management

5.2.15 Standards by themselves will not change clinical behaviour. The process of dissemination and implementation can be enhanced by practice development, which is an important tool for translating aspirations into better clinical care. The following example shows that practice development projects require time and resources as well as the commitment of staff at all levels in the organisation, but that they can be effective in raising standards of care.

Achieving Dignified Care for Older People through Practice Development: A systematic approach

A 1 year practice development project in a rehabilitation ward for older people was undertaken to develop the quality of rehabilitation practice and to explore the potential for nurses to work as case managers.

The baseline data showed that the culture of the ward reflected a custodial approach to patient care. There was a lack of effective clinical leadership and a poor understanding of the rehabilitation needs of older people. It was concluded that changes to practice were needed before a case management approach to care could be considered. A systematic practice development approach was adopted, incorporating pre- and post-development evaluation methods. A comparison ward was used to identify the impact of the project on clinical practice.

The project supervisor was the external facilitator and the project leader was the ward manager, released part-time from her ward manager role to act as internal facilitator. The work of the project included developing an action plan out of the baseline data collected at the start of the project. This consisted of five strategies for action:

- The development of a philosophy for practice
- Attendance at development days and workshops
- The introduction of practice changes
- The development of clinical leadership
- The development of nursing auxiliary competence.

The development strategy focused on facilitating nurses and other members of the multidisciplinary team in the process of questioning their own attitudes, beliefs and values and beginning to challenge their own clinical practice. Attention was also paid to supporting the staff through the conflict and stress involved in making changes.

Ongoing work was aimed at implementing cultural and structural changes agreed by the multidisciplinary team, supported by research evidence, in order to establish new norms of clinical practice and leadership. As a result of the project the ward team was in a much better position to a case management approach to patient care, and to implement the development needs identified within the post-evaluation data.

McCormack and Wright (1999)

5.2.16 **In summary**, older patients are the least satisfied of all age groups with the care that they receive from the NHS when they are acutely ill. The care they receive often fails to meet their most basic needs for food, fluid, rest, activity and elimination, let alone meeting their psychological needs. Current standards of care do not foster older people's sense of independence and self-direction and their dignity and self-respect are undermined. This is compounded by their lack of involvement in

care planning. Some of the problems of nursing older patients can be traced to the changing nature of work in acute settings, which is increasing in complexity, technological sophistication and specialisation. The nursing care of older patients is mainly deficient in terms of the exercise of fundamental skills. The standards for care summarised above are designed to ensure that older patients are treated with respect. The care that they receive must not only be clinically effective and

Recommendations for Action

NHS Executive to:

- Develop a standard assessment process which attends to the biographical, physical, psychological, spiritual and cognitive needs of patients.

Research Funding Bodies (such as the NHS Research and Development Programme) to:

- Allocate resources for programmes of research to:
 - improve the evidence base of nursing interventions
 - evaluate models of practice development in older people settings
 - evaluate models of care management in service delivery

Directors of Nursing to:

- Prepare an action plan for endorsement of the clinical governance committee setting out how standards will be implemented in all wards that care for patients over 60 years.
- Implement audit systems to monitor standards
- Ensure that there are enough staff in acute wards to feed patients who require help and that "Eating Matters" (University of Newcastle 1997) is implemented in practice.
- Ensure benchmarks on staffing levels and skill mix are undertaken and reported to the Trust Board.
- Ensure nurses have access to libraries and computers to improve the evidence base of practice and practice developments.
- Ensure all practitioners have knowledge, skills and expertise in caring for older adults eg. assessment, discharge planning, nutritional assessment. A programme of continuing education in the fundamental skills of nursing should be provided in each trust.
- Ensure that users and carers are involved in planning and evaluating their care.

technically competent but provided in a way that enhances their dignity, autonomy, independence and privacy.

5.3 **LEADERSHIP, MANAGEMENT AND ROLE MODELLING**

5.3.1 Issues and concerns relating to leadership, management and role modelling have emerged from all aspects of our work. This is an area where new nursing roles need to be developed, where career pathways need to be mapped out and inter-disciplinary and multi-disciplinary leadership needs to be strengthened.

5.3.2 **Experts in care:** Specialists in the care of older people, in medicine, nursing and the allied health professions are limited in number. The availability of expert staff for role modelling and problem solving is very important in facilitating high quality care (HAS 2000 1998). Ideally, all patients should have access to specialists at all stages of the acute care pathway, which includes accident and emergency, acute care, discharge, and continuing care.

5.3.3 The gerontological nurse specialist (GNS) could play an important leadership role in the care of older people. According to a recent press release from the Royal College of Nursing and Help the Aged, central elements of the GNS role would include: "...expert understanding of the ageing process, specialist and generic nursing skills, an approach of working in partnership with the older person, and a focus on raising standards and developing practice in all settings through leadership, teaching and mentoring. The specialist older people's nurse would also act as a key link for the older person, pulling in other skills and expertise as needed and co-ordinating input across services." The GNS would not be confined to one setting, but could work across all health and social services, boosting nursing input in care homes, people's own homes, community services or hospitals.

5.3.4 The appointment of nurse consultants in the care of older people is also aimed at improving direct patient care, providing leadership and raising the profile of older people in acute

settings. The difference between gerontological nurse specialists and nurse consultants in the care of older people - as in other specialist fields of nursing - will have to be worked out in practice. It has been suggested that the nurse consultant, who is envisioned as more highly academically qualified than the Level III nurse (DH 1999), might play a more prominent role in research. A nurse consultant would also be responsible for case management, and for leading service development and practice at a higher level than the nurse specialist. Nurse consultants could be prime movers in changing the kind of care that older people receive in acute settings and action is needed to ensure that they become widespread across the UK.

5.3.5 **Ward leaders:** While expert practitioners provide one strand of clinical leadership, the role of the ward leader is also crucial. Not all ward leaders will be designated expert practitioners in the nursing care of older people, yet the key to good nursing also lies with them. The consensus of the Sounding Board Event was that over time ward leaders have been downgraded and lost their patient focus. As they have taken on more management tasks, they have inevitably become less available to nursing staff. Although managerial functions are clearly important in the modern NHS, some allowance must be made to ensure that ward leaders can provide some hands-on care so that they can act as a role model for junior staff. There is a lack of support for new ward leaders, who need to be developed to act as champions of successful models of care and supported in this role by nurses, and others, in senior management. Two modern approaches to leadership are Leading Empowered Organisations (LEO) programme and the Royal College of Nursing Ward Leadership Project provides another model through which ward leaders can be developed and supported.

RCN Ward Leadership Project

Between 1994-1997 the RCN conducted an investigation in 4 Trusts into the role of the ward leader. The project aimed to promote better practice by identifying the skills needed by ward leaders to make them more effective, then demonstrating how these skills could be transferred to nurses and patients.

A number of practical experiential techniques were used. All the work was rooted in the nurses' own experience of nursing practice. Action learning provided a framework for many of the interventions. In addition, the project used mentorship, personal development plans, workshops, observations of care and patient stories.

Five themes were identified as the areas where participants needed to develop their skills to become patient-centred clinical leaders:

- Learning to manage self
- Building, developing and managing effective relationships with team members
- Patient focus
- Networking (internal and external)
- Increased political awareness

Feedback from ward leaders indicated that work-based learning, perceived as accessible and relevant, was key to their success. At the end of the 3-year project, other nurses found significant differences in the team.

The RCN is currently implementing a second phase of the programme, evaluating the effect of the tool kit derived from the findings of the first phase

Royal College of Nursing (1997)

5.3.6 **Career pathways:** There is a need to develop a coherent career pathway for nurses working with older people. This needs to offer opportunities for training and advancement for all nurses working with older people, starting at the level of the junior qualified nurse through to nurse consultant. The proposed career framework set out in the nursing strategy *Making a Difference* (DH 1999) provides the model. Expert practitioners at level III (clinical nurse specialists) and level IV (nurse consultant) are needed in every Trust. The pathway should also include opportunities for advancement and training for health care assistants

5.3.7 The process of change requires continual support and encouragement. *Making A Difference* requires the use of clinical supervision to help identify, support and develop nurse leaders and potential leaders. Clinical supervision and mentorship have been identified as helping to provide a sense of security and purpose for nursing staff working with older people who are acutely ill.

5.3.8 **Inter-disciplinary and multi-disciplinary leadership:** Local boundaries can also be a stumbling block to high quality care involving a range of services. Although the boundary between health and social care will require reorganisation at a high level, clinicians and managers of local services must mobilise to

overcome these boundaries until more appropriate organisational arrangements are put in place. One solution, which has been tried in Manchester, is a forum open to all who are interested in the care of older people. The Manchester Elderly Care Association (MECA) invites trust staff, community nurses, social services staff and employees in residential and nursing homes to meet monthly to share ideas and develop their professional social networks. Speakers present a topic to stimulate group discussion and problem solving. Recent topics have included the use and care of hearing aids, dental health, palliative care and new treatments for dementia.

5.3.9 Each trust should consider establishing a committee to promote the interests of older people within their organisation. A multi-disciplinary forum set up by the CE at Central Manchester Healthcare Trust in response to HAS 2000 provides a model. The remit of the group is to review and improve services for older patients. Topics currently under review include continence, discharge planning, mental health, nutrition, education and training. In Manchester, the success of this forum is at least partly due to the fact that it is chaired by a nurse specialising in the care of older people. In addition to chairing the forum, she leads the development of services, strategic direction and supports excellence in clinical practice. This trust has also pioneered the use of champions for the needs of older people. Champions are named individuals in each ward and at each level of the organisational hierarchy whose stated aim is to protect and promote the interests of older patients. Champions can highlight the training needs of staff and could play an important role in implementing clinical governance.

5.3.10 **In summary**, the need for expert/specialist roles in nursing is well recognised. Gerontological nurse specialists and nurse consultants are two roles that are currently being developed to provide professional leadership in the care of older people. In the end, the skills and knowledge required for nursing older patients need to become part of the training of all nurses. However, it will require time for the education and training of nurses to respond to the changing age distribution of patients and their changing needs. Until that time, nurse specialists and consultants will be needed.

Recommendations for Action

Chief Nursing Officers to:

- Promote clinical leadership for the care of older people within NHS Organisations
- Ensure that a coherent career pathway is developed for nurses specialising in the care of older people.

NHS Trusts, Primary Care Trusts, Primary Care Groups, Health Authorities to take action in the following areas:

- Establish a forum for promoting older people's care linked to clinical governance structure
- Identify champions for older people in all wards and departments where the predominant age group is over 60 years.
- Ensure that therapeutic care is delivered by improving the skills base of health care professionals and by promoting multi-disciplinary teamwork.
- Audit staffing levels, review skill mix, administrative support and training of staff in all clinical areas where care for older people is provided.

Directors of Nursing to:

- Ensure effective ward based clinical leadership that addresses problems in nursing practice.
- Promote and develop opportunities for nurse consultants with specialist gerontology nursing skills.

5.4 EDUCATION, TRAINING AND RECRUITMENT

5.4.1 The review of the literature and other evidence gathered in the course of this study strongly suggests that current nursing practice with older patients and their carers is deficient across a range of care environments. In many cases, standards of care do not meet the expectations of patients and their families, the current policy goals of the NHS, nor the aspirations of the nursing profession. Undoubtedly there are many contributing factors, but some responsibility must be attributed to the failure of current education, both generalist and specialist, at pre-and post registration levels, to adequately prepare practitioners to deliver high quality care.

Critiques of current educational practice:

5.4.2 Recent reports, including *Fitness for Practice* (United Kingdom Central Council 1999), identified the need to ensure that students acquire fundamental knowledge and skills. Deficiencies in current knowledge and skills were highlighted during the sounding board event. The report goes on to state that education and training must take account of social changes that impact on the needs of the population including the changing demographic profile of the population, developments in long term care arrangements, changing attitudes to age and changes in the family that affect the availability of informal carers. In addition the role of the nurse in

rehabilitation of patients with chronic illnesses and disabilities should feature more prominently in pre-registration programmes. *Fitness for Practice* gives nurse educators and senior nurses an important opportunity to look at again at the preparation of nurses to work with older people and to give the subject a higher, more coherent, profile within the programme leading to registration.

- 5.4.3 Nolan *et al* (1997) were commissioned by the ENB to explore the nurses contribution to rehabilitation. The research revealed that although professionals working in acute settings are increasingly involved with patients who have rehabilitation and continuing care needs, issues related to rehabilitation, disability and chronic illness are “all but invisible” in nursing curricula. Indeed analysis revealed a lack of structure, cohesion and consistency in most programmes.
- 5.4.4 This finding has led the ENB to fund independent research into the effectiveness of education in preparing nurses to work with older patients and their carers. This work will articulate the professional knowledge and skills and attitudes to care for older people effectively and sensitively through changes to the education and training of nurses (Masterson 1997).
- 5.4.5 Taken together these reports identify the need to re-examine the core knowledge and skills of nurses. The majority of people requiring nursing care are elderly and nurse training must reflect the changing demography and health needs of the population. An ethos of increasing independence, rehabilitation and palliation needs to permeate the whole curriculum and more attention needs to be given to the nursing care of patients with chronic illnesses, multiple diseases and disabilities.

Content of future curricula:

- 5.4.6 SNMAC's review of the literature and the sounding board event indicated a need for radical changes to the pre-registration curriculum.

5.4.7 The adult branch of nursing needs to be reoriented and reconfigured to highlight the needs of older patients in relation to all topics and disease categories. The fundamental knowledge and skills identified earlier in the report need to be central, compulsory and explicitly related to meeting the needs of older people. Educators must ensure that all nurses qualify with the knowledge and skills to deliver high quality care to older patients. The current changes in nurse education in *Making a Difference* provide a good opportunity to review curricula and ensure the recommendations of the report are incorporated. In this way all nurses working in acute settings will eventually come to have the necessary expertise in this area. In the meantime the deficiencies will need to be addressed by the development of specialists in this area of nursing practice.

5.4.8 Concern was expressed at the Sounding Board Event about the lack of attention to ethical issues in nursing curricula. Currently, there is generally poor awareness among nurses about how to deal with ethical issues encountered in practice. Nurses need an explicit ethical framework that acknowledges the older person's dignity and autonomy. They need to be able to assist older people to make meaningful choices and to act as their advocate, when required, in the multidisciplinary team. To do this, they need to be able to locate decisions in a clear ethical code of conduct, for example, in relation to advance directives. Action is required by all levels of the NHS system with the lead taken by providers of education and training. Education providers should review pre and post registration programmes to ensure that ethics and ethical decision making is covered to a sufficient depth to meet statutory requirements (English National Board 1994; English National Board 2000; United Kingdom Central Council 1999).

Innovation in teaching practices:

5.4.9 Innovative approaches to education and training are required to change attitudes to older people and to facilitate their involvement in their care. Teaching and learning strategies should enable exploration of the emotional, relational and value-laden components of caring for older patients. Experiential learning, problem based and evidence-based learning and the use of case studies are examples of some effective approaches. Knowing the “person” is fundamental to the provision of care that is sensitive to the needs of the individual older person and is often referred to as establishing an individual “biography”. Patients’ biographies have been successfully used to develop nurses’ understanding of the needs of older people. The following is an account of one such biography. It is adapted from a real situation.

5.4.10 Nurses and care workers involved in this work used their new understanding of the importance of an individual’s biography to develop their assessment process and explore new ways of capturing individual biography in the development of care plans. This process could be adapted and applied to the context of training in nursing older people who are acutely ill.

Joan is an 84 years old lady who has been transferred from the DGH for ongoing care following a fall and fractured neck of femur. She is no longer able to cope at home on her own.

Care Plan:

Identified needs: Incontinent; poor appetite; needs help to mobilise.

Joan died four weeks after her admission to the care home.

Her obituary appeared in the local paper and read:

Fowler, Joan, died peacefully in her sleep at Sharedcare, West Midlands. Beloved wife, mother and grandmother, lover and friend. Doctor of philosophy, teacher, adviser, carer, justice of the peace and centre of her community. Artist, writer, lover of music, bible smuggler and a passion for life.

Staff were shocked and amazed to learn about the ‘real’ Joan – a person they had never got to know whilst she was in their care.

Re-orientation and education of academic staff

5.4.11 The change of content and focus of pre-registration programmes will require that a considerable number of staff will need to develop their own knowledge and skills if they are to be able to teach the programme. This will necessitate academic staff working in clinical areas for a proportion of their time.

Multi-professional education

5.4.12 Professional tribalism, inter-professional rivalry and failures in communication among different professional groups have been identified as problems in the NHS. Inter-professional curriculum development and shared learning, at both pre-registration and post-registration levels, could facilitate communication among the different professional groups responsible for the care of older people. Education should focus not only on courses for individuals, but also on the development of teamwork in practice. Collaboration within the multidisciplinary team, recognising shared challenges, having a regular team briefing, and moving towards a blurring of roles are all factors fostering a sense of belonging for staff (Davies *et al* 1999). However effective teamwork does not just happen and is difficult to achieve (Miller *et al* 1999). Educationalists are an important resource in moving this agenda forward through the creation of

opportunities to develop mutual understanding, communication and team-working skills through structured learning. Miller *et al* advocate a model that is patient focused, interactive, problem based using clinical cases, and ongoing throughout the pre-registration course

Education, practice and research

5.4.13 The importance of education and training linking with developments in research, policy and practice cannot be over-emphasised. One project that links education, training, research and policy with practice settings has established seven Care of Older People nursing positions. The co-ordinating centre in an academic nursing department will provide a programme of educational activities relating to the nursing care of older people. Topics will include change management and evidence based nursing, clinical governance, inter-professional and multi-agency practice, and greater user and carer involvement.

CELEC Action Research Project: Care for older people

This collaborative venture between The Central and East London Education Consortium (CELEC) and St Bartholomew School of Nursing & Midwifery, City University, began in January 2000. CELEC is funding seven Lead R&D Nurses: Care for older people posts, for a period of three years and is providing the funding to establish a Co-ordinating Centre for these posts at City University. The Co-ordinating Centre will provide a programme of educational activities related to nursing care for older people to support the Lead R&D Nurses in their work, including teaching on research and policy, change management and evidence based nursing. The aims of this nurse-led initiative are to contribute to a better understanding of clinical governance and to foster a change in culture to better support learners, inter-professional and multi-agency practice and greater user and carer involvement. The co-ordinating University will undertake evaluation of these new roles, using an action research framework.

Meyer and Cotter (1999)

5.4.14 ***The image of nursing and recruitment into the profession:***

The urgent need to recruit a much larger nursing work force is widely acknowledged. Current recruitment campaigns tend to focus on the needs of children and young adults. This may lead to false expectations about the nature of nursing in acute settings, leading to disillusionment and disappointment with nursing careers. It is important that recruitment campaigns reflect the fact that most patients needing acute care are now older, often suffer from multiple or chronic diseases, require rehabilitation and may have social problems as a result of poverty and social dislocation. At the same time, recruitment campaigns should challenge the stereotype of nursing older patients as unskilled and unrewarding. In fact, nursing older patients needs to be portrayed as requiring the integration of knowledge, values and practice.

5.4.15 The image of nursing is important, but if this field of nursing is to be seen as a good job, then concrete steps need to be taken to ensure that it compares favourably with other comparable occupations. In addition to feeling valued, nurses need to have rewards that are commensurate with their skills. More attention needs to be paid to the career structure and to education and training, both of which are important components of workers assessments of their jobs. There is increasing recognition that clinical supervision is an important factor linked to staff morale, and to the quality of care they can provide. Research in the United States has shown that nurses autonomy (i.e. their ability to make decisions in their areas of clinical competence and the control they exert over their work) has an important effect, not only on job satisfaction and morale, but on patient outcomes as well (Aiken *et al* 1994).

5.4.16 Anti-ageist practice must be fostered not only in relation to users of the health service but in relation to the employment policies of health service Trusts. *Making a Difference* recommends a number of initiatives to encourage experienced nurses back into the workforce. These include family friendly, flexible working patterns. Older people

additionally need nurses from similar black and minority ethnic groups and those who are nearer their generation in age because they may be more likely to understand their needs than younger inexperienced nurses. These positive employment strategies should include a programme of management development into senior posts for the older nurse.

5.4.17 **In summary**, the core skills of the adult nurse working with older people who are acutely ill need to be re-examined. Educational courses have been criticised for:

- Failing to attend to social changes that affect the age structure of the population, attitudes to age, and the availability of informal carers.
- The omission of important topics, such as rehabilitation, disability and chronic illness, as well as ethical issues in the care of older people
- Inadequate attention to fundamental nursing skills, particularly in relation to nutrition, skin integrity and continence.
- Lack of innovation in teaching and learning strategies to develop appropriate attitudes and communication skills in new nurses.

5.4.18 The majority of people requiring nursing care are old and nurse training must reflect the changing demography and health care needs of the population. An ethos of increasing independence, rehabilitation and palliation needs to permeate the whole curriculum and more attention needs to be given to the nursing care of patients with chronic illnesses, multiple diseases and disabilities. In addition, the image of nursing in the media, particularly in recruitment campaigns should reflect the fact that most adults in acute care settings are now drawn from older age groups.

Recommendations for Action

NHS Executive to:

- Ensure the nursing care of older people features more prominently in recruitment and return to nursing campaigns.

The regulating body for nursing, midwifery and health visiting to:

- Review all adult nursing pre and post – registration programmes to ensure that the content is evidence based and include skills that are fundamental to the care of older patients. Teaching and learning strategies need to be capable of developing the knowledge, skills and attitudes related to the nursing care of older people through clearly articulated curriculum content.
- Ensure that service users and carers are involved in curriculum development, delivery and evaluation.

Educational institutions, education commissioning and service providers must work in partnership to:

- Review teaching, learning and assessment strategies within pre-registration programmes to ensure that students are enabled to acquire fundamental nursing skills and associated knowledge.
- Ensure that programme development and delivery is supported by lecturers and practitioners with expertise in care of older people.
- Interim measures to develop post-registration evidence based courses and work based learning opportunities in the care of older people including medication management, management of dementia, comprehensive physical and psychological assessment (particularly in A&E) and pre and post – operative care special care needs.
- Involve users and carers in the development of training and educational courses.
- Establish lecturer practitioner posts in the care of older people.
- Ensure that staff working in acute settings are clinically up-to-date in the care of older people.
- Develop courses that prepare nurses to work in Intermediate Care Settings and as part of specialist outreach teams.
- Recruit more mature entrants into nursing whose life experience could enhance the care they give to older people.
- Invest in leadership training for all sister and charge nurses targeting all ward areas that care for patients over 60 years old.

NHS Trusts, Primary Care Trusts, Primary Care Groups, Health Authorities to:

- Review recruitment practices to ensure that they include applicants' interest in and attitudes towards working with older people as significant criteria in hiring nurses to work with adults in acute settings.
- Ensure that hiring policies and work practices do not create barriers to nurses from different ethnic backgrounds from working with older patients in acute settings.
- Give priority to the training and development of Health Care Assistants. Ideally, each HCA should undertake training to NVQ levels 2 and 3.

5.5 ORGANISATIONAL AND ENVIRONMENTAL FACTORS

Hospital environments:

5.5.1 The physical environment of acute care settings is often an obstacle to providing high quality care. For example, a stroke patient who is being nursed in a small side room crammed with all the usual hospital furniture may be effectively trapped until someone comes to help. A patient who has had a stroke needs space to practice some of the new mobility skills that they had been taught. Structural problems such as toilets that are too small can be disabling for older people and force them to rely on staff rather than encouraging independence. Bathroom and toilet doors need to be lockable to ensure privacy. If they are not, then older people will not want to use them. This results in a loss of independence, since they may prefer to use a commode or a bedpan or will have embarrassing and undignified stays in hospital. Each environment needs to be assessed and redesigned if necessary to improve its rehabilitation potential. The level of noise on busy wards is often unacceptably high increasing the patients discomfort and contributing to their disorientation.

Frequently mentioned problems with physical environment include:

- Outdated, often Victorian, wards with badly designed toilet and bathroom facilities that do not allow for privacy or promote independence, for example, toilet doors that do not lock.
- Lack of space in ward areas for mobilisation and therapy, causing particular difficulties for wheelchair users.
- Lack of space for storing equipment creating a hazardous environment.
- Lack of a separate interview room and beds too close together for private conversations with patients/family members.

- Poor lighting and slippery or uneven floor surfaces that increase the risk of falling
- Mixed sex wards create obstacles for providing dignified care.

5.5.2 **Deprivation of resources:** In addition, staff often lack even minimum resources that would enable them to care for older patients. Some of the essential resources that are often unavailable or in short supply include:

- Linen and pillows
- Continence pads
- Spare clothing
- Aids to mobility/eating/dressing/bathing
- Hospital mattresses and redistributing equipment essential to the maintenance of skin integrity
- Personal items such as toothbrushes and toothpaste, soap, razors, combs and hairbrushes
- Essential items are often shared among wards wasting valuable staff time

5.5.3 Shortage of equipment, or the provision of inappropriate equipment, has been identified as an important issue affecting delivery of care to older people (HAS 2000 1998). This applies throughout the hospital system starting at Accident and Emergency where there is a lack of appropriate trolleys and chairs and continues in hospital where essential resources, such as food and bed linen, are also sometimes in short supply. Staff can spend a long time searching outside the immediate care environment for basic supplies of linen and technical equipment, which is a waste of valuable staff time.

5.5.4 **Alternatives to hospital:** The National Beds Inquiry (Department of Health 2000) envisaged (as one option for the future) a network of intermediate care services in support of hospital beds. These will act both to prevent unnecessary admission to acute hospitals and to provide more appropriate alternatives for

recuperation and rehabilitation. This idea is spelled out more fully in the NHS plan, which states that 5,000 intermediate care, and 1,700 supported intermediate places will be set up.

5.5.5 Intermediate care can produce improved outcomes for older patients, but there are dangers. First, the process of transfer can be disorientating and would need to be managed in a way that would limit any detrimental effects on older peoples' health. Second, allocating patients to a service based solely on their age is

that it could lead to a second class service for older people, either in reality or in public perception. Perhaps intermediate care should be seen as appropriate for all adults rather than just for older people, to ensure equal access to diagnostic and specialist treatment facilities. In other words, the selection criteria for admission to intermediate care should be based on patient need, rather than age. Within these caveats, nurse-led intermediate care for older people is a viable option, as shown in the following example.

Sir Alfred Jones Memorial Hospital – Liverpool

The key objectives of the scheme agreed at its inception are:

- Facilitation of early discharge from acute care
- Maximisation of support to primary care through integrated rehabilitation
- Joint case management (from health and social services)
- GP access to beds to prevent acute admission.

There is no on-site medical cover but a rich nursing skill mix allows for expert nursing cover over the 24-hour period. Admissions and discharges are managed by the nurse practitioners who have negotiated agreement to refer directly back to the acute Trust, by-passing A&E, should the need arise. Medical cover is provided by a local GP with dedicated time for the Unit.

An 'in-house' needs driven development programme, managed by the occupational therapist, is offered to the health practitioner assistants, who have developed a generic range of nursing and therapy support skills. Arrangements are also in place for them to achieve NVQs at Levels II and III. Thus while the OT and physiotherapist on the team are managed by the senior nurse, there are times when they, in turn, manage the nursing support workers. This flexible cross-boundary working typifies the way in which the team work together. There is also an in-house development programme for E-grade nurses to help them develop into the Nurse Practitioner role.

There is no recruitment problem in the Unit despite major difficulties elsewhere in the locality. Comments from the staff suggest that there is a demanding but fulfilling role for the nurses and therapists; support workers are offered a career progression and a fulfilling holistic role.

Patients are accepted from the acute Trust and the community in a ratio of about 69:31. 90% of admissions are people over 60 years old, with 57% being female. 73% live in proximity or nearby. The median length of stay is 14 days (within the range 0-381). 74% of patients are discharged home.

Patients evaluate their time in the Unit positively, enjoying being comfortable and cared for in a pleasant environment. The Unit has attracted high quality, highly motivated and enthusiastic staff. By crossing professional boundaries they maximise the integrated care approach. Staff motivation has been harnessed for the good of the patient, to create a culture of re-enablement not dependency.

Bennet (1999)

5.5.6 The advantages and disadvantages of intermediate care need to be evaluated over time. In the past, many intermediate care projects were set up on an *ad hoc* basis often with comparatively short term funding (Vaughan and Lathlean 1999). There is therefore little evidence of their effectiveness as service delivery models. Evaluation, if it has been conducted at all, has been at the level of the individual project rather than examining it in the context of a network of services. Whole systems approach to research and development is called for, whereby the local network of services is investigated, because the effectiveness of one form of service delivery may in part depend on the other services offered in that geographical area.

5.5.7 **Continuity of care:** The importance of better communication and co-ordination between acute and community sectors cannot be over-emphasised. Care for older people should be viewed as a circular process where, as soon as the older person is admitted to an acute bed, planning for their return to the community is initiated. When the person returns to home, intervention by community or outreach staff is focused on maximising independence and preventing readmission to hospital. In the event of another acute crisis occurring, the community teams need to begin liaison with hospital staff to facilitate discharge immediately. Avoiding problems at the acute/community interface depends on effective liaison

arrangements between providers (statutory, independent and voluntary agencies) as well as two-way communication between acute and community care.

5.5.8 Liaison nurses can be an effective way of managing the interface between acute and community services. Liaison nurses follow-up older people discharged from hospital and work closely with primary care to provide a comprehensive assessment service in the community. They often focus on very elderly people, those who have declined other assessments (e.g. by social services), people who have experienced frequent admissions to hospital, those living alone and those finding it difficult to maintain a regular regime of medication. The comprehensive assessment they provide both reinforces and underpins the discharge planning process begun in hospital. Liaison nurses help prevent older people being admitted to hospital simply because other, more appropriate alternatives have not been considered (Fletcher 1999).

Example: The Liaison Nurse Role (*Community Liaison Service, Oxfordshire Community Health NHS Trust operating from John Radcliffe Hospital, Oxford*)

As part of a range of joint initiatives to facilitate the transfer of patients between a large teaching hospital and a neighbouring community trust, positions were established for two gerontological liaison nurses. The kinds of patients where their interventions can be most valuable have complex discharge needs. An older patient who no longer needs acute care but requires rehabilitation following a fall is the type of patient who would benefit from this kind of nursing intervention. The liaison nurse will arrange for transfer to a community hospital or to home with appropriate support services. Part of their role involves the education of practitioners about discharge planning and the kinds of services that are available to older patients in the community. In addition, their work has led to all practitioners placing greater value and trust in expert nursing assessment, which in turn has made nurse-led discharge planning more acceptable in this acute setting.

5.5.9 There are in fact a range of models for facilitating the transition between hospital and home, e.g. discharge support schemes staffed by paid employees or by volunteers, rapid response teams aimed at preventing hospital admission, and different schemes for facilitating the transfer of information. These models show that practitioners are aware of the problems surrounding discharge. The next step will be to implement a programme of systematic evaluation and comparison on which recommendations about service delivery and organisation can be based.

Multidisciplinary Teams

5.5.10 The relationship between multidisciplinary collaboration and quality of care is well established (Cutler 1998; Davies *et al* 1999). However, communication among team members is often hampered by the lack of shared philosophy or approach to care. Multidisciplinary education and training can help to break down barriers to communication. Enquiry based learning at ward level, such as case conferences, could form an important aspect of multi-disciplinary training to facilitate better inter-disciplinary working. Multidisciplinary teams should enhance professional identity rather than blur professional roles, yet this can only be done when roles and responsibilities are clear. Where there is lack of clarity, conflict will exist between profession-based clinical and corporate team responsibilities. This leads to fragmented care, based on uncertainty and fear of change, and the formation of professional cliques to defend their interests. If teams are to work well together, they need to spend time developing their relationships as well as focusing on their tasks.

Support services

5.5.11 Support services have an important role in ensuring quality care. Catering, cleaning, laundry and maintenance services may be working to fixed routines that do not always accommodate the needs of patients for flexible services. Delivery on some of the standards

previously outlined depends in part on the close liaison between nursing and ancillary staff, such as porters, domestic staff, laundry and maintenance staff. It has been argued that nurses should have management control over support services, through for example delegated budgets, to ensure a co-ordinated service. An example of a trust wide, strategic approach to nutrition is given in section 5.1.3 above.

Organisational boundaries

5.5.12 Local services vary in the services they provide for older people, particularly in the number of acute beds and the primary and community services. Research has shown that those health authorities with good provision of social and community health services and below average in-patient use achieve outcomes as good as those with above average in-patient use (Audit Commission 2000). Combining this information with the results of surveys of older people that indicate their general preference for care to be delivered at home rather than in hospital suggests that social and community services could be developed to take some of the stress off acute in-patient settings.

5.5.13 However, we need to ensure that by expanding community services we do not simply shift problems from one setting to another. We also need to be alert to the danger of placing an even greater burden on informal carers who may themselves be old or infirm. Local authorities are required to assess carers needs independently of the person requiring care. Demand for services, such as night-sitting, respite, aids and adaptations and home care is increasing. A recent survey of carers' experiences revealed that the period around discharge from hospital was particularly difficult and stressful and was not well managed from their perspective. The NHS plan also sets out a strategy for home care and other supports to enable 50,000 more people to live independently at home. Guidance is available on the range of continuing care services that should be available and discharge arrangements for people with continuing health and social

needs. Health Authorities are required to describe the services that are available for continuing care in their local area and to state the criteria to be used in decisions about eligibility for NHS care. The importance of discussion, consultation and continued communication with users and carers in the discharge process, including providing a written continuing care plan was emphasised by the Royal Commission on Long Term Care (1999) and is included in the NHS Plan (Department of Health 2000).

5.5.14 The co-ordination and integration of health and social services is recognised as an area requiring much further work. Definitions of which aspects of care are “health” responsibilities and which are “social” vary across the UK and lead to anomalies. One of the main planks underlying current policy is the idea of patient-focused services. Achieving this aim will require co-ordination of the full multi-disciplinary team across primary and secondary care as well as social services. The introduction of care pathways could be a catalyst if they can ensure that *the right person gives the right care at the right time*, rather than simply reinforcing traditional professional boundaries. Primary care trusts as commissioners and providers have a major influence over the co-ordination and organisation of care.

Partners in caring: users, carers and communities:

5.5.15 The involvement of users and carers is a crucial aspect of the delivery of good quality care. However, a number of factors work against user and carer involvement. Professionals often have neither the knowledge nor the skills to implement the concept effectively. Older people often have low expectations and lack assertiveness in making their needs known. Frequently the carers of older people are old themselves and, for reasons similar to those of older users, are unable to make their needs known.

5.5.16 Health professionals sometimes neglect the needs of carers, fearing that the perceptions of care may be different from those of their relatives (Meyer *et al* 1999). There is, in addition, some evidence that health professionals tend to pay lip service to the philosophy of user and carer involvement, and, whilst agreeing in research interviews that it is important, may actively work against it in their individual interactions with patients and their carers (Meyer 1995).

5.5.17 While evidence-based guidelines about working with carers exist (Leicester Community Care Unit 1998) these need to be publicised more widely. Evidence-based guidelines on working with users have yet to be developed. Work by the College of Health and the Royal College of Nursing on the involvement of older users in audit programmes may be the basis of further developments in this area (Kelson 1998; Kelson 1999) Important points with regard to involving users and carers is that:

- This needs to be negotiated at a local level
- Staff need to be trained in how to implement the policy
- Staff need to be pro-active in creating a culture where older patients and their families feel they have a right to contribute to care planning and implementation
- Staff need to work in partnership with carers and will ensure that their needs are assessed and addressed as part of the review process
- Training, preparation and time for adjustment needs to be provided for carers, particularly those who face a new set of challenges through the disability of another, e.g. someone who now has to care for another with a stroke.

5.5.18 Many wards now develop strong links with local communities. This can be seen as an extension of partnerships in care. Local people can be involved in negotiations about future service developments, in fund-raising and voluntary work. The use of trained volunteers on acute wards appears to enhance the experience of patients and family members. All these initiatives create a sense of ownership among local communities and are areas where nurses can take the lead. Health Authorities, trusts and PCTs need to be better organised in incorporating users and families' views into the monitoring of services and review of NSF standards.

5.5.19 **In summary**, the physical environment of acute care was often designed for another era and may be an impediment to active rehabilitation. Essential resources, such as pillows and dressings, are often in short supply wasting staff time and frustrating attempts to raise standards of care. The NHS plan announced the government's intention to establish a large number of intermediate care beds that will benefit around 150,000 patients each year and take some of the pressure off

acute beds. Models of nurse-led intermediate care, one of which is described above, are available for emulation. Research needs to be initiated now so that different ways of organising and managing intermediate care can be evaluated and compared. Older people prefer to be treated at home if possible and the NHS plan announced more support to enable people to live independently. Care needs to be taken not to place an intolerable burden on informal carers whose needs must be assessed as well as the patients. Problems with continuity of care are well recognised and some potential solutions, such as liaison nurses, integration of the multi-disciplinary team and nurses being delegated the authority to manage support services, have been proposed. Again, each of these proposals needs to be subject to empirical evaluation.

Recommendations for Action

NHS Trusts, Primary Care Trusts, Primary Care Groups, Health Authorities to take action in the following areas:

- Improve communications and co-ordination of care between acute and community health care settings.
- Develop the role of liaison nurses to facilitate patient transitions between health care settings.
- Develop and evaluate a range of nurse led intermediate care services.
- Ensure regular hotel services audit for all basic support requirements.
- Create equipment libraries
- Regularly review support services, catering, laundry, maintenance, to provide a more flexible service.
- Implement the recommendations of "Eating Matters" (University of Newcastle Centre for Health Services Research 1997) - a resource for improving dietary care in hospital.

Chapter 6. Summary and Conclusions

- 6.1** Changes in the age composition of the population mean that the majority of patients in acute settings are now old. Older people have complex health care needs, often combining acute and chronic illnesses compounded by problems of poverty and a lack of social support. Older patients are the least satisfied of all age groups with the care that they receive from the NHS when they are acutely ill. There is a great deal of evidence to support the conclusion that the care that older people receive often fails to meet their most basic needs for food, fluid, rest, activity and elimination and the psychological and mental health needs of older people are often entirely neglected in acute health care settings. The nursing care of older patients is mainly deficient in terms of fundamental skills, such as communication and helping a patient to maintain their nutritional status, skin integrity and continence. The goal of this report is to ensure that all older people in acute settings receive care which is not only clinically effective and technically competent but provided in a way that enhances their dignity, autonomy, independence and privacy.
- 6.2** The need for expert/specialist roles in nursing is well recognised. Gerontological nurse specialists and nurse consultants are two roles that are currently being developed to provide professional leadership in the care of older people. In the end, the skills and knowledge required for nursing older patients need to become part of the training of all nurses. However, it will require time for the education and training of nurses to respond to the changing age distribution of patients and their changing needs. Until that time, nurse specialists and consultants will be needed to bridge the gap. Ward leadership skills need to be developed and supported so that experienced nurses are available to act as role models to junior staff.
- 6.3** This report suggests that the educational preparation of nurses has not kept pace with the changing health needs of the population. Nurse training must reflect the changing demography and health care needs of the population. The core skills of the adult nurse working with older people who are acutely ill need to be re-examined. An ethos of increasing independence, rehabilitation and palliation needs to permeate the whole curriculum and more attention needs to be given to the nursing care of patients with chronic illnesses, multiple diseases and disabilities. In addition, the image of nursing in the media, particularly in recruitment campaigns, needs to reflect the fact that most adults in acute care settings are now drawn from older age groups.
- 6.4** Finally, the physical environment of acute care can be an impediment to providing good quality care, as well as the lack of essential resources which are often in short supply. In criticising the overall standards of care delivered to older people, SNMAC is cognisant of the fact that current conditions are far from ideal. The NHS plan recognises that many of the problems identified in this report are due to chronic under-funding of the service and additional investment has been promised in the next few years. Many of the reforms, such as intention to establish a large number of intermediate care beds, are designed specifically to improve the care of older people. In addition, the NHS plan announced more support to enable people to live independently.

6.5 There is a real opportunity in the NHS plan and with the publication of the NSF for older people to radically revise the nursing care of older people. SNMAC has identified three main areas for action.

- *Education:* The NHS, universities and other educational institutions are asked to consider the current way of preparing nurses to work in acute settings in the light of this report, which has identified major deficiencies in educational provision.
- *Practice:* The NHS must ensure that clinical governance is given priority for all practitioners. Human resource management practices need to be reviewed so that staff with positive attitudes and appropriate skills for nursing older people are recruited and retained in acute health care settings.
- *Leadership:* Every NHS organisation needs to appoint a named individual to promote the interests of older people in general and to implement the NSF.

Chapter 7. Recommendations for Action

Our study revealed that the nursing care of older people is physically hard and emotionally taxing. The care of older people is perceived as requiring less knowledge, skill and technical expertise than many other nursing jobs. However, most of the patients now requiring care in acute setting are old. This means that if overall standards of acute care are to rise in the NHS much more attention needs to be paid to our attitudes towards older people, the provisions that are made for them, and the ways in which nurses are prepared in education and in training, to meet their needs.

NHS Executive to:

- Develop a standard assessment process which attends to the biographical, physical, psychological, spiritual and cognitive needs of patients as directed by forthcoming guidance.
- Ensure the nursing care of older people features more prominently in recruitment and return to nursing campaigns.

Chief Nursing Officers in England and Wales to:

- Promote clinical leadership for the care of older people within NHS Organisations.
- Ensure that a coherent career pathway is developed for nurses specialising in the care of older people.

Directors of Nursing to:

- Prepare an action plan for endorsement of the clinical governance committee setting out how standards will be implemented in all wards that care for patients over 60 years.
- Implement audit systems to monitor standards.
- Ensure that there are enough staff in acute wards to help older people eat and drink and that "Eating Matters" (University of Newcastle

Centre for Health Services Research 1997) is implemented in practice.

- Ensure benchmarks on staffing levels and skill mix are undertaken and reported to the Trust Board.
- Ensure nurses have access to libraries and computers to improve the evidence base of practice and practice developments.
- Ensure all practitioners have knowledge, skills and expertise in caring for older adults eg. assessment, discharge planning, nutritional assessment. A programme of continuing education in the fundamental skills of nursing should be provided in each trust.
- Ensure that users and carers are involved in planning and evaluating their care.
- Identify champions for older people in all wards and departments where the average age is over 60 years.

The regulating body for nursing, midwifery and health visiting to:

- Review all adult nursing pre and post - registration programmes to ensure that the content is evidence based and includes skills that are fundamental to the care of older patients. Teaching and learning strategies need to be capable of developing knowledge, skills and attitudes related to the nursing care of older people through clearly articulated curriculum.
- Ensure that service users and carers are involved in curriculum development, delivery and evaluation.

Educational institutions, education commissioning and service providers must work in partnership to:

- Review teaching, learning and assessment strategies within pre-registration programmes to ensure that students are enabled to acquire fundamental nursing skills and associated knowledge.
- Ensure that programme development and delivery is supported by lecturers and practitioners with expertise in care of older people.
- Agree interim measures to develop post-registration evidence based courses in the care of older people including medication management, management of dementia, comprehensive physical and psychological assessment (particularly in A&E) and pre and post – operative care special care needs.
- Involve users and carers in the development of training and educational courses.
- Establish lecturer practitioner posts in the care of older people.
- Ensure that staff working in acute settings are clinically up-to-date in the care of older people.
- Invest in leadership training for all sister and charge nurses targeting all ward areas that care for patients over 60 years old.
- Develop courses that prepare nurses to work in Intermediate Care Settings and as part of specialist outreach teams.

Research Funding Bodies (such as the NHS Research and Development Programme) to:

Allocate resources for programmes of research to:

- improve the evidence base of nursing interventions
- evaluate models of practice development in older people settings

- evaluate models of care management in service delivery

NHS Trusts, Primary Care Trusts, Primary Care Groups, Health Authorities to take action in the following areas:

Leadership, management and role modelling

Directors of Nursing to:

- Ensure effective ward based clinical leadership that addresses problems in nursing practice
- Promote opportunities for nurse consultants with specialist gerontology nursing skills
- Ensure that therapeutic care is delivered by improving the skills base of health care professionals and by promoting multi-disciplinary teamwork
- Audit staffing levels, review skill mix, administrative support and training of staff in all clinical areas where care for older people is provided
- Establish a forum for promoting older people's care linked to clinical governance structure
- Review recruitment practices to ensure that they include applicants' interest in and attitudes towards working with older people as significant criteria in hiring nurses to work with adults in acute settings.

Education and training

- Ensure that hiring policies and work practices do not create barriers to nurses from different ethnic backgrounds from working with older patients in acute settings.
- Recruit more mature entrants into nursing whose life experience could enhance the care they give to older people.

- Give priority to the training and development of Health Care Assistants. Ideally, each HCA should undertake training to NVQ levels 2 and 3.

Organisations and Environmental factors

- Improve communications and co-ordination of care between acute and community health care settings.
- Develop the role of liaison nurses to facilitate patient transitions between health care settings.
- Develop and evaluate a range of nurse led intermediate care services.
- Ensure regular hotel services audit for all basic support requirements.
- Create equipment libraries
- Regularly review support services, catering, laundry, maintenance, to provide a more flexible service.
- Implement the recommendations of “Eating Matters” (University of Newcastle Centre for Health Services Research 1997) - a resource for improving dietary care in hospital.

Appendix 1 References

1. Aiken, L.H., Smith, H.L., and Lake, E.T. (1994). *Lower Medicare mortality among a set of hospitals known for good nursing care*, Medical Care 32 pp.771-87.
2. Audit Commission (2000) *The Way to go Home: rehabilitation and remedial services for older people: national report*, London: Audit Commission.
3. Bennett, T. (1999) *Development of Sir Alfred Jones Memorial Hospital* Paper presented at the Intermediate Care Conference. King's Fund: London.
4. Clinical Standards Advisory Group (1998) *Community Health Care for Elderly People*, London: The Stationery Office.
5. Cutler, I. (1998) *Tributaries to the team*, Nursing Times 94, (2) pp.40-41.
6. Davies, S., Laker, S. & Ellis, L. (1999) *Dignity on the Ward: Promoting excellence in care. Good practice in Acute Hospital Care for Older People*, London: Help the Aged.
7. Department of Health (1996) *Hospital Catering: delivering a quality service*, London: Department of Health.
8. Department of Health (1999) *Making a Difference*, London: Department of Health.
9. Department of Health (2000) *The NHS Plan, A plan for investment, A Plan for reform*, London: The Stationary Office.
10. Department of Health (2000) *Shaping the Future: Long term planning for hospitals and related services. Consultation document on the findings of the National Beds Inquiry*, London: Department of Health.
11. English National Board (1994) *Guidelines for Pre-Registration Nursing Programmes of Education: Creating Life-Long Learners*, London: ENB.
12. English National Board (2000) *Education in Focus: strengthening pre-registration nursing and midwifery education: curriculum guidance and requirements*, London: ENB.
13. Fletcher, S. (1999) *Liaison Nursing*, Unpublished paper presented to the SNMAC Care of Older People Sub-Group.
14. Goldsmith, M. (1996) *Hearing the Voice of People with Dementia: Opportunities and Obstacles*, London: Jessica Kingsley.
15. Health Advisory Service (1997) *Services for people who are elderly: Addressing the balance. The multi-disciplinary assessment of elderly people and the delivery of high quality care*, London: The Stationery Office.
16. Health Advisory Service 2000 (1998) *Not because they are old: An independent inquiry into the care of older people on acute wards in general hospitals*, London: HAS 2000.
17. Health Advisory Service 2000 (1999) *Standards for Health and Social Care Services for Older People*, Brighton: HAS 2000 and Pavilion Publishing Ltd.
18. Hunter, S. (1997) *Dementia: Challenges and New Directions*, London: Jessica Kingsley.
19. Joy, P.J., Carter, D.E. and Smith, L.N. (2000) *The Evolving Educational Needs of Nurses Caring for the Older Adult: A Literature Review (with particular reference to community settings)*, Journal of Advanced Nursing 31(5) pp. 1039-1045.

20. Kelson, M. (1998) *Promoting patient involvement in clinical audit: Practical guidance on achieving effective involvement*, London: College of Health.
21. Kelson, M. (1999) *National Sentinel Audits involving older people: A guide to involving older people in local clinical audit activity*, London: Royal College of Nursing.
22. Kertzer, D. & Laslett, P. (1995) *Ageing in the Past: Demography, Society and Old Age*: Berkeley.
23. Kitwood, T. (1997) *Dementia Reconsidered: The person comes first*, Buckingham: Open University Press.
24. Koch, T., Webb, C., Williams, A. (1995) *Listening to the voices of elderly people: an existential-phenomenological approach to quality assurance*, *Journal of Clinical Nursing*: 4: pp.185-193.
25. Leicester Community Care Unit (1998) *Guidelines for working with carers*, Leicester: University of Leicester Community Care Unit.
26. Lloyd-Sherlock, P. (2000) *Population Ageing in Developed and Developing Regions: Implications for Health Policy*: *Social Science and Medicine* 51:887-895.
27. McCormack, B. (1998) *An exploration of the Theoretical Framework Underpinning the Autonomy of Older People in Hospital and its Relationship to Professional Nursing Practice*, Unpublished D.Phil thesis, Department of Educational Studies, University of Oxford.
28. McCormack, B. & Wright, J. (1999) *Achieving dignified care for older people through practice development: A systematic approach*, *NT Research*, 4,5, 340-352.
29. Maryon-Davis, A. & Bristow, A. (1999) *Managing Nutrition in Hospital: A recipe for quality*, London: Nuffield Trust.
30. Masterton, A. (1997) *The Nursing and Health Visiting Contribution to the Continuing Care of Older People*, London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
31. Meyer, J. (1995) *Lay Participation in Care in a Hospital Setting: An action research study*, Unpublished Ph.D. thesis, University of London.
32. Meyer, J., Bridges, J., Spilsbury, K. (1999) *Caring for older people in acute settings: Lessons learnt from an action research study in accident and emergency*, *NT Research* 4 (5) 327-339.
33. Meyer, J. & Cotter, A. (1999) *CELEC Action Research Project: Care of Older People*, Unpublished proposal submitted to and funded by Central and East London Education Consortium. London: City University.
34. National Confidential Enquiry into Perioperative Deaths (1999) *Extremes of age, The 1999 Report of the National Enquiry into Perioperative Deaths*. London: National Confidential Enquiry into Perioperative Deaths.
35. Nolan, M., Booth, A. & Nolan, J. (1997) *New Directions in rehabilitation: exploring the nursing contribution*, London: English National Board for Nursing Midwifery and Health Visiting.
36. Nolan, M., & Nolan, J. (1998) *Stroke 1: a paradigm case in nursing rehabilitation*, *British Journal of Nursing* 7 (6) 316-322.
37. Nolan, M., & Nolan, J. (1998) *Stroke 2: expanding the nurse's role in stroke rehabilitation*, *British Journal of Nursing* 7 (7) 388-392.
38. Nolan, M., & Nolan, J. (1998) *Rehabilitation: scope for improvement in current practice*, *British Journal of Nursing* 7 (9) 522-526.

39. Nolan, M., & Nolan, J. (1999) *Rehabilitation, chronic illness and disability: the missing elements in nurse education*, Journal of Advanced Nursing 29 (4) 958-966.
40. Norton, D., McClaren, R., Exton-Smith, A.N. (1962) *An investigation into geriatric nursing problems in hospital*, National Corporation for the Care of Older People.
41. Norton, D., McClaren, R., Exton-Smith, A.N. (1975) *An investigation into geriatric nursing problems in hospital*, Edinburgh: Churchill Livingstone.
42. Open University Department of Health and Social Welfare (1984) *A Systematic Approach to Nursing Care: An Introductory Student Pack*, Open University Press.
43. Office of Public Censuses and Surveys (1991) *Persons Aged 60 and Over: Great Britain*, London OPCS.
44. Office for National Statistics (2000) *Health in England 1998: investigating the links between social inequalities and health: a survey of adults aged 16 and over in England carried out by the Social Survey Division of ONS on behalf of the Health Education Authority*, London: The Stationery Office.
45. Prince, M. (1997) *The Need for Research on Dementia in Developing Countries*, Tropical Medicine and International Health. 2(10), 993-1000.
46. Pursey, A. & Luker, K. (1995) *Attitudes and stereotypes: nurses' work with older people*, Journal of Advanced Nursing, 22, 547-555.
47. Reed, J. & Bond, S. (1991) *Nurses' assessment of elderly patients in hospital*, International Journal of Nursing Studies 28,1, 55-64.
48. Royal College of Nursing (1997) *RCN Ward Nursing Leadership Project: A journey to patient centred leadership*, London: Royal College of Nursing.
49. Royal Commission on Long Term Care (1999) *With respect to old age: long term care - rights and responsibilities: a report by the Royal Commission on Long Term Care: community care and informal care*, London: The Stationary Office.
50. United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Fitness for Practice - the UKCC Commission for Nursing and Midwifery Education*, London: UKCC.
51. University of Newcastle Centre for Health Services Research (1997) *Eating Matters: a resource for improving dietary care in hospitals*, Newcastle: University of Newcastle.
52. Vaughan, B. & Lathlean, J. (1999) *Intermediate Care*, London: King's Fund.
53. Victor, C.R. (1999) *Demographic and epidemiological trends In Redfern SJ & Ross F (ed) 1999, Nursing Older People* Edinburgh: Churchill Livingstone pp.19-35.
54. Waters, K.R. & Luker, K.A. (1996) *Staff perspectives on the role of the nurse in rehabilitation wards for elderly people*, Journal of Clinical Nursing 5 105-114.

Appendix 2

Standing Nursing and Midwifery Advisory Committee

Mr Tony Bell OBE	Acting Chief Executive, Alder Hey Hospital, Liverpool (SNMAC) Chairman)
Professor Dame Jill Macleod Clark	Head of School and Deputy Dean of the Faculty of Medicine, Health and Biological Sciences, Southampton (SNMAC Vice-Chair)
Mrs Susan Studdy *	Dean, City University, St Bartholomew School of Nursing and Midwifery (until March 2000) (Chair of SNMAC Older People Sub-Group)
Mr John Archer	Director of Nursing and Service Development NWRO
Mrs Vicky Bailey	Senior Nurse and Midwife, Nottingham
Mr Philip Boulter	Co-ordinator of Nursing/Manager Outreach Services - Lifecare NHS Trust
Miss Kate Caldwell	Director of Midwifery Services - Royal Devon and Exeter Hospital
Professor Mel Chevannes	Head of Section, Department of Nursing and Midwifery, De Montfort University
Mrs Ann Close *	Nursing Director - Dudley Group of Hospitals
Dr Annette Dearmun	Principal Lecturer Practitioner, Oxford Brookes University, Oxford
Mrs Susan Elworthy	Executive Director, N. Glamorgan NHS Trust
Mrs Sally Fletcher *	Director of Quality (Executive Director), South Lancashire
Ms Denise Hagel *	Director of Nursing, Essex Rivers NHS Trust
Mrs Gina Higginbottom	Lecturer, Health Visiting, Primary Health Care, Sheffield University
Mrs Gillian Husband	Senior Lecturer, Research & Practice Development, Sunderland University
Mrs Jean Lawrence *	Senior Nurse (Infection Control), Leeds
Mr Dave McNicholas	Senior ITU Nurse, Sunderland
Mrs Susan Nicholas *	Nurse Manager, Older People - Penzance
Ms Sue Norman	Chief Executive/Registrar of the UKCC
Mrs Karen Parsley *	Director of Nursing, Brighton
Mrs Grethe Ridgway	Director of Nursing Practice and Executive Director, Southampton
Mr Harry Teaney	Public Health and Contracts Advisor: Clwyd
Ms Meryl Thomas	Director Midwifery, Education and Practice ENB
Ex-Officio Members	
Mrs Sylvia Denton	Deputy for President, Royal College of Nursing
Mrs Lorna Muirhead	President, Royal College of Midwives

* Also member of Older People Sub-Group

Experts co-opted to the Sub-Group

Ms Yvonne Awenat	Gerontology Nurse Specialist, Central Manchester NHS Trust (until July 2000)
Ms Tricia Bennett	Nurse Co-ordinator, Intermediate Care, Liverpool
Ms Sue Davies	Lecturer in Nursing, University of Sheffield
Professor Brendan Mc Cormack	Co-Director, Gerontology Programme, RCN Institute (until July 2000)
Mrs Mary Skarrats	Senior Nurse, Elderly Care Unit, Southampton
Ms Lynette Snowden	ENB, London
Ms Deborah Sturdy	Specialist Nurse, Dementia and Elderly Care (until July 2000)

Research Team

Dr Angela Cotter	City University, St Bartholomew's School of Nursing and Midwifery, London
Professor Julienne Meyer	

Editor

Dr Elizabeth West	Senior Research Fellow, RCN Institute
-------------------	---------------------------------------

SNMAC Secretariat

Mrs Patricia Noons	Professional Secretary
Mrs Melissa Naylor	Administrative Secretary
Mr Steve Ralph	Administrative Support
Ms Janie Navarro	Administrative Support

Appendix 3 Acknowledgements

The Standing Nursing and Midwifery Advisory Committee are grateful to the members of the sub-group, the research team, officials in UK Health Departments, the many nurses and other professionals, some of whom are acknowledged below, who contributed to a Sounding Board Conference, or otherwise assisted the Sub-group.

Jayne Wright	Community Liaison Nurse, Oxford Community Trust
Jane Offord	Senior Lead Nurse – Medical Directorate, Ipswich
Ann Dalby	Manager – Portsmouth Healthcare
Sue Simmonds	Service Development Adviser – Older People – HAS 2000
Val Hattersley	Sister – Bassetlaw Hospital, Notts
Gill Turner	Lead Clinician – Elderly Care Unit, Southampton
Carol Ball	Research Fellow – (Critical Care), St Bartholomew School of Nursing & Midwifery
Alan Crump	Senior Nurse- Seacroft Hospital, Leeds (MSc in MH Gerontology)
Barbara Vaughan	Consultant- Intermediate Care, Oxford
Glyn Coventry	Senior Lecturer – West Midlands
Jonathan Ellis	Campaign Organiser, Help the Aged
Annette Hanny	Clinical Nurse Manager Community and Primary Care
Janet Monkman	Nurse Executive Director – Walsgrove Hospitals NHS Trust, Coventry
Jacqueline Docherty	Nurse Executive Director – King’s College Hospital, Camberwell
Dorothy Styles	The Relatives & Residents Association
John Tait	The Relatives & Residents Association
Sam Cocksedge	Ward Sister – Royal Sussex County Hospital, Brighton
Debbie Reynolds	Ward Manager – Essex Rivers Healthcare NHS Trust
Nicky Pendleton	Trust Development Manager
Jackie Bridges	Lead Research and Development Nurse: Care of Older People, City University, St Bartholomew School of Nursing and Midwifery
Patricia Davies	Research and development nurse – Care of Older People, City University
Margaret Butterworth	CRAC Dementia, North London
Marisa Silverman	Old Age Psychiatry, The Maudsley Hospital
Jan Reed	University of Northumbria, Newcastle-upon-Tyne
George Giarchi	Head of Community Research & Liaison, University of Plymouth
Karen Wilson	Director Clinical Quality, North Mersey Community Trust, Rathbone Hospital
Betty Arrol	Policy Officer Health, Age Concern England
Elizabeth Onslow	Elderly Trauma Nurse Specialist, Orthopaedic Unit, Southampton General Hospital –
Fiona Muldoon	Sister, Southampton General Hospital
Annie O’Neill	Clinical Nurse Specialist – Guy’s Palliative Care Team, London
Caroline Oakley	Assistant Director Community Services, Pembrokeshire & Derwent NHS Trust
Theresa Neate	Senior District Nurse, Cardiff and District NHS Trust
Kay Morgan	Nursing Sister, Discharge Liaison, Bronglais
Toni Lynch	A & E Sister – Royal London Hospital
Marie Gray	Lecturer Practitioner – A & E, Kings College London
Julie Pearce	Associate Director of Nursing – Southampton General
Bernie Cuthal	Assistant Chief Executive – North Mersey Community Trust
Kate Fieldsend	Care Co-ordinator – North Mersey
Jane Bentley	City University, St Bartholomew School of Nursing and Midwifery
Karen Spilman	City University, St Bartholomew School of Nursing and Midwifery
Susan Scott	Adviser in Nursing Practice, RCN
Annette Goulden	Nursing Officer, Department of Health London (until July 2000)

Appendix 4

Stakeholder Sounding Board Event – 31st January 2000

INTRODUCTION

The purpose of this event was to obtain views from stakeholders in nursing research, education and practice, and from user and carer representatives. 5 Groups focussed on 10 core themes identified in the preliminary study and were asked to define the barriers to, and facilitators of, implementation of the standards. The event, facilitated by Julienne Meyer and Angela Cotter from City University, produced a number of suggestions that greatly influenced the writing of this report. Some of the themes that emerged are summarised below.

Poor Care Environment

Nurses should have more control over support services e.g. laundry and catering services to facilitate high quality care.

Education and Training

Participants identified the need to review pre- and post-registration nursing curricula to ensure that they meet the specialist needs of older people and suggested that at least one day of the PREP (post-registration education and practice) requirements be concerned with care for older people. A joint educational approach was needed to care for older people across professionals and agencies and in partnership with users and carers to focus on sharing good practice together with appraisal systems to facilitate improving care and highlight educational needs.

Involving Users and Carer

Participants agreed that the input of relatives/carers must be included as part of the assessment process and negotiated as part of any contractual agreement. There was much support for a Carers' Council or a support group for older people themselves to underpin their involvement in health services.

Inadequate Workforce

Participants suggested that contracting had contributed to a lack of organisational commitment to holistic practice and poor multi-disciplinary working had encouraged fragmentation of care. Systems to underpin effective practice need to be developed e.g. supervision and support, education in establishing positive relationships with carers and volunteers. One qualified nurse with specialist training in care of older people was needed on each shift in every setting where older people in the acute phase of illness are nursed.

Ageism

Trust policies should be reviewed for ageist practice. The promotion of care of older people needs to be fundamental to these policies.

Research and Development

Participants agreed that systems of clinical governance must promote quality of care of older people as a priority. A review of assessment tools, guidelines and protocols in care for older people should be undertaken by NICE (National Institute for Clinical Excellence) and Practice Development should focus on integrated care pathways across acute primary and secondary care, to include the use of shared care plans and user-held records. Information Technology would play a key role in the development of these for the future and evaluation of new approaches to care is essential.

Assessment and evaluation of individual patient care

Participants recognised that poor assessment and evaluation of individualised care was another barrier to implementing person-centred care for older people who are acutely ill. A national assessment framework leading to an 'older persons' care pathway that incorporated evaluation should be developed. The input of relatives/carers must be included as part of the assessment process and negotiated as part of any contractual agreement.

Managing seamless care

Patient centred care was thought to be paramount with the same standards of care the same whatever the setting in which care for older people during an acute phase of illness is carried out. All professionals working with older people need to use the same terminology so that they and service users and carers are not confused and thus communication hindered. Nursing leadership should be developed at all levels to meet the interests of the older person and influence change.

Quality of working life

Quality of working life was seen as needing improvement with low morale and apathy among nurses, who were fatigued by working under pressure. The emotionally demanding nature of dealing with older people did not appear to be recognised e.g. death & dying, loss. Each health service organisation needed to make explicit its value base with regards to the care for older people.

Cultural differences

The general lack of awareness of cultural difference and lack of sensitivity to spiritual needs was reported. Nurses needed a coherent value base with an ethical framework to support work with older people. Further research should be undertaken to ascertain why it is that people from minority ethnic groups do not access acute health services as much as the epidemiological evidence would suggest they could do. Attention should be given to achieving a profile of the nursing workforce that reflects the local minority ethnic population. It was felt especially important that this be achieved in relation to nurse leaders, and in education.

Appendix 5

SNMAC Care of Older People Sub-Group Visioning Meeting – 12 May 2000

INTRODUCTION

The sub-group (membership attached at Appendix 1) met on 12 May to consider and build on four of the visioning issues raised at the Sounding Board Event. The meeting (facilitated by Brendan McCormack) provided a valuable contribution to the content of the main report. Some of the key themes are summarised below.

Assessment

The importance of ensuring the involvement of families and understanding relationships.

That assessment was a continuous process and should not be used to record merely physical details. Recognition of the significance of 'autobiographical' assessment upon admission to which details are added at a pace dictated by the older person and that some individuals may be able to compose their own biographies, input to forms/procedures was needed.

Appropriate education and training needed to ensure nurses were able to carry out comprehensive assessment. This should include identifying the priorities within an individuals' life which made them unique.

Leaders

Suggestion that a 'Tsar' for Older People be created.

Clinical leadership/work-based learning should be used to promote role models within workplace.

The creation of an older person's 'champion' forum – a multi disciplinary clinical governance structure set in each trust with user/carer and geriatrician representation which would be given autonomy/power to enact change.

Encourage the development of a system of elderly key workers, especially within Trusts that do not have dedicated older care units.

There should be strong role models in all clinical settings who lead excellence in practice with Older People.

Practice

Essential fundamental aspects of care apply to all locations. All older people must receive access and equity in services provided.

Consideration of health and safety legislation (eg. disposal of food if untouched after 20minutes) in light of needs of elderly.

A standardised and validated assessment tool should be available.

The Chief Executive should be responsible for making things happen and the development of a mechanism to feedback when problems arise.

Anti-agist policies should match racism and equality practices

NHS Trusts to take responsibility to ensure that all practitioners caring for adult patients have knowledge, skill and expertise in caring for Older People.

Training

The adult branch of nurse training should ensure care of older people is central to the curriculum.

Recruitment literature should reflect the high number of 'older people' who need to be nursed.

Any Recruitment/Marketing Campaign must emphasise that 'older people' form the largest 'group'.



First published: April 2001

© Crown Copyright
Produced by the Department of Health

23668 1p 3k Apr 01 (ABB)

CHLORINE FREE PAPER

If you require further FREE copies of this publication please contact:
Department of Health Publications
PO Box 777
London SE1 6XH
Fax: 01623 724524
E-mail: doh@prolog.uk.com

Please quote reference 23668 when ordering.

It is also available on our website at:
www.doh.gov.uk/snmac.htm

The text of this document may be reproduced without formal permission or charge for personal or in-house use.