Improving Older People’s Acute Care

Impact Report

June 2015
Acknowledgements

The improving older people’s acute care (OPAC) team would like to thank all those who have contributed to this work. This includes:

- colleagues across NHSScotland who have actively engaged in this work and shared their ideas and learning with each other
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- the OPAC Programme Board who has provided advice, guidance and governance to this work.
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Foreword

Providing excellence in care for every person within our NHS can be challenging. In particular with growing demands and faster throughput, making sure that older people, who may have specific needs, receive excellence in care at all times is critical. That is why improving care for older people across NHSScotland is a national priority.

Over the 25 years to 2037, the proportion of over 65s in the population as a whole is projected to increase from 17% to 25%. In the same period, the number of people over 75 is expected to rise by 86%, with this group accounting for around 8% of the whole population. Older people usually have longer stays in hospital, higher mortality and rates of readmission, and they are more likely to be discharged to residential care.

In 2011, Scottish Government reiterated its commitment to improving older people’s acute care by announcing a programme of inspections of older people’s acute care by Healthcare Improvement Scotland in order to assess care, drive improvements where needed, and to provide public assurance that NHSScotland treats older people with respect, compassion and dignity.

The Older People’s Acute Care improvement programme (OPAC) was commissioned by the Scottish Government in 2012 and this report captures the essence of its impact. The programme addresses all three quality ambitions of safe, effective and person-centred care and there can be no doubt that it has raised awareness of key issues, supported staff to share experiences and learn together, and has influenced practice. This report is not the end of the process, but it represents a step forward in ensuring older people in hospital get the care they need. The challenge now is to build on the progress that’s been made and continue to work collaboratively to share the learning that has taken place.

Fiona McQueen
Chief Nursing Officer, Scottish Government
Introduction and context

In common with most European countries, Scotland’s population is ageing. People are living longer and by 2037, over 65s are expected to make up a quarter of the population. Caring for older people is becoming ‘core business’ for hospitals. We know that older people are more likely to be admitted as an emergency and to have multiple and complex health problems. We also know that the average age of a hospital inpatient is over 80 and unplanned admissions for the over 75s increased by 26% in the 10 years to 2013–2014.

Recent years have seen an increasing focus on reducing or avoiding admissions and delivering care at home and in community settings where possible. However, sometimes admission to hospital is essential and the drive to improve acute care for older people is a national priority. Healthcare Improvement Scotland has been leading a national programme of work with NHS board colleagues to improve older people’s acute care in NHSScotland since April 2012.

The programme has focused initially on two critical areas:

- **frailty** - ensuring older people in hospital identified with frailty receive comprehensive geriatric assessment (CGA) within 24 hours of admission
- **delirium** - increasing early identification and management of delirium.

The decision to focus on these particular areas of care was informed by a review of literature, themes emerging from the Healthcare Improvement Scotland inspection of older people’s acute hospitals reports, and an extensive period of consultation with stakeholders.

NHS board colleagues were consulted with to understand and identify what help they would need to support improvements. At the end of this period of scoping and consultation, all NHS boards nominated at least one local test site and team to take part in the work.
Where we started from

Within the agreed test sites, the aims of the programme were to:

- assess 95% of patients over the age of 75 for delirium and
- ensure patients over the age of 75, identified with frailty, receive a CGA within 24 hours.

The programme aimed to improve the quality of care by supporting local teams to make practical and sustainable changes so that good practice could become both common and consistent.

What we did

We adopted a collaborative approach that included:

- developing specific tools and resources to be adopted, or adapted, locally
- supporting test sites to develop processes for recording and reporting their progress
- creating a range of opportunities for sharing learning and experience between local teams, and
- encouraging local teams to identify areas for improvement, acting as a source of advice and information.
Tools and resources

The programme developed easy-to-use, evidence-based tools and resources in response to requests from clinical staff. Working with colleagues across Scotland, we developed criteria for identifying frailty and a delirium toolkit. A corresponding process for collecting data on a monthly basis using a flash report template helped teams record their progress, improvement activity and changes achieved, for example the number of patients assessed for delirium, changes in the number of falls or the effect on length of stay.

Frailty

Local teams were supported with testing a range of approaches to identifying and co-ordinating the care of people with frailty. Improving the identification and management of frailty: A case study report of innovation on four acute sites in NHS Scotland gives full details of the work to identify frailty and ensure rapid CGA in four NHS boards.

www.knowledge.scot.nhs.uk/improvingcareforolderpeople/resources.aspx
Delirium

We worked with the Scottish Delirium Association to design, develop, test and adapt a range of tools and resources to assess, manage and review delirium. One of these resources is the delirium care bundle. This sets out critical actions for the period immediately after delirium is identified and links to the Scottish Delirium Association’s evidence-based pathway. The care bundle uses the acronym TIME (Think/Triggers, Investigate/Intervene, Manage, Engage/Explore). It guides staff to consider triggers for delirium, investigate underlying causes, implement an appropriate management plan and engage both patient and family members.

As part of this work, we looked at the delivery of care during an episode of delirium. The resulting report focused on the experience of patients, their families and staff and highlighted the importance of taking a person-centred approach. *Staff, patients and families experiences of giving and receiving care during an episode of delirium in an acute hospital care setting*, was published in September 2013 and describes the use of emotional touch-points to capture individual experiences.


All of the delirium tools and resources are included in the *Delirium Toolkit*. 
Raising awareness

When the programme began in April 2012, routine assessment for frailty and delirium was limited. We have worked with colleagues across Scotland to raise awareness of existing good practice and the importance of assessing for frailty and the early identification and management of delirium.

“The word ‘frail’ didn’t mean much before but awareness of both frailty and delirium has increased. The impact (of frailty) on clinical resources was not previously appreciated. It is now.”
– Allied Health Professional, NHS Ayrshire & Arran

“In 2012, there was not much awareness of delirium and no structured testing. Now, it’s embedded.”
– Staff Nurse, NHS Greater Glasgow and Clyde

“The OPAC programme has had a massive impact. It highlighted the importance of delirium to managers so we now have the resources to address it at the level of the individual patient.”
– Charge Nurse, NHS Tayside

“Working in collaboration with HIS has really helped raise the profile of delirium across Scotland.”
– Consultant Geriatrician, NHS Lothian

Run chart showing increasing staff confidence in recognising hypoactive delirium as result of delirium education programme in NHS Ayrshire & Arran
Engaging and empowering frontline staff is well recognised as a vital ingredient for improving the quality of care and encouraging innovation. Throughout the programme, we have engaged a wide range of clinicians, organised a range of continuing professional development accredited national and local events, facilitated cross-site visits and held online improvement clinics, WebEx and conference calls. NHS board teams particularly valued the improvement planning and engagement events because of the opportunity for networking, sharing learning by discussing experience and ideas, exploring examples of good practice, and identifying opportunities and challenges.

Feedback has highlighted that participants found these approaches very useful as a way to share and validate ideas, learn about what was, or was not, working at other test sites and plan their next steps.

“You can feel isolated so it’s good to have support. The events put me in touch with colleagues elsewhere with similar interests. I had lots of ideas but the events gave me the opportunity to learn about improvement methodology and to network.”

– Staff Nurse, NHS Highland

“It is inspiring hearing about work being taken forward in other boards and (it) promotes enthusiasm to take forward improvement in (my) own area.”

– Staff Nurse, NHS Borders
In terms of engagement with local clinical teams and NHS board management, the programme has been successful. Consultant Geriatrician and Scottish Chair of the British Geriatrics Society, Dr Jennifer Burns said:

“The improvement programme has focused on where people are delivering care. At the national meetings, there was a definite sense of momentum and enthusiasm. A major achievement has been in supporting and promoting champions and allowing managers and clinicians to have a focus on this element of care.”

Her view was echoed by fellow consultant, Dr Christine McAlpine, national specialty adviser for geriatric medicine in Scotland and a member of the OPAC Programme Board who described the impact of the programme as:

“A combination of awareness and people making concrete changes.”

She added: “Having improvement advisors really made a difference. The programme provided capacity for people to come in and help move things forward, allowing the improvements achieved to take root. Management teams and clinical directors all took it on and were supportive. People realised that the programme could help them solve problems.”

By working collaboratively, showing links between the OPAC programme and other national workstreams and focusing on the positive outcomes for patients and their families, we have generated energy and interest around the work.
Communicating and sharing

A common theme among local team members was the value of sharing learning and experience with colleagues from other NHS boards at improvement events, during WebEx calls and through contact with the national team. The tools and resources developed are available online along with flash reports from test sites and from the team, links to more information, feedback and information from events.

www.improvingcareforolderpeople.scot.nhs.uk

Learning from the experience of patients, relatives and staff has also played an important role in the programme. In addition to the emotional touch-points technique used to explore the experience of care during an episode of delirium, digital stories and staff focus groups helped NHS board teams to understand and learn from patients’ experience and their own.

One of our goals was to share learning between local teams and for teams to learn from the experience of individual patients using Learn from Experience cards. Designed to be completed by patients and relatives and carers while discussing their experience with a member of the ward team, the cards ask two questions:

- What did we get right for you?
- How could we have made your experience during this time even better?

By collecting cards each day and reviewing them weekly, local teams can identify new ways to improve patients’ experience, for example the introduction of mini nursing stations to enhance observation.

“The introduction of mini nursing stations means we can respond more quickly to patients’ care needs.”

– Staff Nurse, NHS Ayrshire & Arran
Reporting progress

Test site teams are sharing their experience, results and learning regularly through WebEx calls and the improvement events. Teams have planned, conducted, assessed and refined small tests of change, and used the flash report template (below) to capture progress and report results. Sharing the reports online and at events give local teams a useful framework for keeping up to date and discussing each other's progress. One local team member said:

“Flash reports – really interesting hearing what was going on locally and how the teams were using PDSA cycles to drive and measure improvement in clinical assessments of the elderly.”

– Charge Nurse, NHS Ayrshire & Arran

Aim: Introduction of a Frailty screening tool within a surgical ward in NHS Lothian by end of November 2013.

Meet the team

Gillian Wilson – Head of Service, Delivering Better Care.
James McWilliams – Advanced Practitioner Delivering Better Care
Sue Spiers – Senior Nurse for Vulnerable Patients
Andrew Coull – Consultant/Clinical Director for Acute Medicine.
Jane Muirhead – Quality & Safety Improvement Manager
Debbie Coleman, Amy Harris, Liaison Nurses, Surgical Elderly Care Assessment Team (SECAT)

A 36 bedded general surgical ward with a varying age range of patients.

Lessons Learned

• Effective planning and communication is essential
• Engagement with staff of all levels and disciplines
• Making visible, supportive and contactable to all staff
• Proactive attitude and buy-in from all staff
• Sharing of information
• Being accepted as part of the team and not seen as outsider
• Support from Senior Nursing/Medical Management relating to future plans
• Positive atmosphere in the clinical area as a result of feedback

Results so far

Reviewed existing pathway and identified key staff. Reviewed existing pathway and agreed changes. Completed a Scoping exercise in Surgical Observation Unit. Further scoping exercise performed in the clinical area. Clinical staff consulted and buy in achieved. Education of screening tools etc and support given to all staff. Data collected – Prescribed additional staff on a rotated basis to cover the ward. Education of screening across the surgical and orthopaedic wards. This will cover the 5 day working week with medical staff continuing to screen patients on Tuesdays. Further support from the team in terms of education, training and on going support.

Appointment of 2 staff nurses on a seconded period to assist with the rollout of frailty screening across the surgical and orthopaedic wards. This will cover the 5 day working week with medical staff continuing to screen at weekends. Continued support from the team to keep momentum high and positive re-enforcement to motivate staff. PDSA cycles continued. Data collected and with the appointment of our SECAT nurses our figures have increased from 30% to 90.9% of patients identified/screened and referred for appropriate interventions.

Further liaison nurse have been appointed to cover the fully 7 day week. We would now like to replicate this in another surgical area within one of our other Acute hospitals using PDSA cycles. Initial consent has been obtained for this to happen.

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Updating NHS Lothian, Delivering Better Care website page.

Contributing to the National Improving Care for Older People workstream at HIS.

Gillian Wilson
– Head of Service, Delivering Better Care.

James McWilliams – Advanced Practitioner Delivering Better Care

Sue Spiers – Senior Nurse for Vulnerable Patients

Andrew Coull – Consultant/Clinical Director for Acute Medicine.

Jane Muirhead – Quality & Safety Improvement Manager

Dianne Coleman, Amy Harris, Liaison Nurses, Surgical Elderly Care Assessment Team (SECAT)
Scrutiny and improvement

A concerted effort has been made to strengthen collaboration between the improvement and inspection functions of Healthcare Improvement Scotland that relate to the care of older people. There is a growing commitment to share and learn from each other in order to support teams with improvement activity. For some of the ward teams, one of the most significant aspects of the OPAC programme was the way it changed their perspective on inspection visits.

Dr Steven Wishart, Consultant Physician in the department of medicine for the elderly at Glasgow’s Southern General Hospital summed it up:

“The attitude was that you would be inspected, then you would receive negative feedback that you would have to go and fix. By joining the two arms (improvement and scrutiny), people know the purpose of the inspection is to see both the positive and the negative and to link that with assistance in how to improve. Over time, visits have come to be seen as more of a positive thing than they were at the beginning.”

Feedback from the national events told a similar story with participants commenting:

“(It’s a) sensible approach to ensure that scrutiny highlights improvement areas in a constructive way.”
– Allied Health Professional, NHS Fife

“(I) previously felt very anxious about inspections and somehow if matters were raised then it was taken personally. However, I feel more encouraged and more positive it will be a learning experience.”
– Charge Nurse, NHS Forth Valley
Impact and outcomes: What difference have we made?

Staff involved in OPAC work locally have described it as “inspirational, supportive” and “hugely important”. They particularly valued the practical tools and support, the shared learning with teams around the country and being able to access help and expertise from the national team when required.

UK recognition of success

The collaborative approach of the OPAC programme has helped develop thinking and practice about the improvement priorities of frailty and delirium. According to the President of the British Geriatrics Society, Professor David Oliver, the result is impressive:

“This is one of the best examples I’ve seen of a properly concerted, national drive to improve quality. A real focus on practical deliverables and a focus on quality improvement is critical. The question I always ask is whose job is it to disseminate good practice at scale and ensure that the rest are as good as the best? It’s not on to leave it as a free-for-all if right now people are receiving poor care so you’ve got to have a mass quality improvement function with strong clinical leadership and backing from the centre. Proper buy-in from the Scottish Government, clinicians fully engaged and a product aimed at driving quality improvement across all (hospitals) in Scotland is commendable.”
Measuring outcomes, spreading improvements

Data being gathered by local OPAC teams is showing how outcomes for patients are beginning to improve. Improvements reported by individual test sites include:

- reduced mean length of stay from 22 days to 8 days NHS Grampian (October 2013–October 2014)
- a 50% decrease in the average number of falls per month in two wards between January 2013 and January 2015* (NHS Greater Glasgow and Clyde)
- an increase to 95% in the number of patients being assessed for delirium between 2013 and 2014 (NHS Highland)
- reduction in re-attendance at the Emergency Department for patients aged 65 or over on Frail Older People’s Pathway from 26% of all attendances - 8% comparing data from January–June 2013 to the same timeframe in 2014 (NHS Ayrshire & Arran)

*Run charts showing 50% decrease in the average number of falls per month in Wards 54 and 55, Southern General Hospital
The changes in clinical practice developed by the initial test sites are now being spread through other wards, departments and hospitals. NHS Tayside is rolling out the use of 4AT from Ninewells Hospital, Dundee to Perth Royal Infirmary. NHS Lothian plans to expand frailty screening from the Royal Infirmary of Edinburgh to the Western General Hospital, Edinburgh, and St John's Hospital, Livingston. NHS Highland aims to introduce delirium identification and early management to its acute sites in Fort William and Inverness.

Using improvement approaches, such as the model for improvement, and education have played an important part in engaging staff. Testing changes on a small scale so that they could be easily refined also helped to make the programme manageable for busy wards. As test sites began to collect data showing the impact on patient outcomes, the staff could see the benefits for themselves.

Financial benefits

Some of the test sites observed that they were saving time, using resources more efficiently and reducing costs. To explore this aspect of the programme’s impact more fully, we commissioned an economic evaluation, in the form of a cost consequence analysis, of a pathway for frail older people in NHS Ayrshire & Arran. The frailty case study report, *Improving the identification and management of frailty: A case study report of innovation on four acute sites in NHSScotland*, contains details of the interim evaluation. A more comprehensive economic evaluation will be included within the Frail Older People’s Pathway analysis due for completion in July 2015.
Case studies

NHS Lothian: Frailty screening reduces length of stay

Frailty screening in three wards in the surgical directorate at the Royal Infirmary of Edinburgh resulted in decreases in three key measures: length of stay, falls and the number of complaints.

“Older people’s care was very limited at the start of the project. Frailty on surgical wards was not recognised but now that we identify frailty, patients with problems are picked up quickly and referred to medicine of the elderly.”

– SECAT Liaison Nurse, NHS Lothian

The project has taken a multidisciplinary approach involving pharmacists, allied healthcare professionals, medical staff and the nursing team in weekly discussions about all patients over 65 years of age. Having concentrated initially on frailty, attention is now turning to delirium. A two-week period of delirium awareness training took place in December 2014.

“With the delirium awareness training and what we have learned from OPAC, falls will continue to decrease.”

– Charge Nurse, NHS Lothian
The Royal Infirmary of Edinburgh also houses the largest orthopaedic department in Scotland, admitting more than 1000 people with hip fractures each year. The appointment of a surgical elderly care assessment team liaison nurse to the department to assess patients for frailty, and review and monitor their progress towards discharge has contributed to an 11% decrease in average length of stay when 2013–2014 is compared to the same period in 2011–2012. Initial data also suggest the frequency of falls is declining.
Amy Harris, SECAT Liaison Nurse, said the improvement programme had affected the orthopaedic department in a number of ways:

“Patients feel better, the senior and charge nurses say the wards feel calmer, the junior doctors feel more supported and the medicine of the elderly doctors feel confident that they know what to expect when they go onto the wards.”

The OPAC programme provided peer support and created opportunities for learning and sharing experiences with colleagues in other parts of Scotland. James McWilliams, Senior Nurse, Quality and Projects, said:

“The OPAC programme has been really good on the national perspective and on collaboration. The peer support has been very valuable. National events have been very useful because we could showcase our work and see what others have done. The networking, learning and sharing was very beneficial.”

For a full description of the Lothian work on frailty screening, see *Improving the identification and management of frailty: A case study report of innovation on four acute sites in NHSScotland.*
Improving care by detecting delirium

Following an older people in acute hospital (OPAH) inspection in early 2014 which highlighted weaknesses in the detection of delirium, the department of medicine for the elderly (DME) at the Southern General Hospital, Glasgow, began work to introduce consistent and reliable assessment processes. The 4AT tool was introduced in the acute medical admissions unit in April 2014. All patients being admitted by the department are assessed and data from the first five months shows 28% of patients had evidence of delirium.

With assessment on admission now being carried out consistently, the DME team has begun to introduce repeat assessment, for example when a person's condition changes or a patient moves wards, because delirium continues to be a risk for the duration of the patient’s hospital stay. The department has begun to use the TIME bundle, not only to manage delirium, but as a guide to supporting prevention.
In common with other sites, education has been critical. As delirium assessment and management is rolled out across the hospital, engagement with the project will need to involve teams in other departments. DME Consultant Physician Dr Steven Wishart explained:

“Junior medical staff change on a regular basis so keeping the level of education up whenever we make any change is a real challenge. My experience from rolling this out so far is that if you don’t get the education right initially, people just don’t come on board. Doing it in a very small area with a small team, it’s quite achievable to educate those people but it becomes a bigger challenge to educate larger staff groups.”

While the focus of the work has been on the identification and management of delirium, the project also creates opportunities to improve the quality of care for older people more generally. As Dr Wishart points out, the elements of the TIME bundle ensure that issues such as nutrition, pain and skin integrity are all considered. Getting these fundamental elements right consistently for all over 65s helps improve older people’s experience of care as a whole.

The next step for the DME team is to embed the new approach to delirium identification and management as acute services for the south of Glasgow consolidate on a single site at the new South Glasgow University Hospital in 2015. Patient pathways from the Victoria infirmary and the Southern General Hospital are being combined due to the opening of the new South Glasgow University Hospital.
NHS Greater Glasgow and Clyde: a local collaborative approach

Following the 2014 OPAH inspection mentioned in the previous section, the clinical team at the Southern General Hospital asked for our support to help them focus on improvement work in delirium care. The ‘Think Best Care for Older People Everywhere’ day was structured as an improvement workshop and focused on opportunities for improvement and building understanding of improvement approaches. The recent inspection created an opportunity to focus on specific areas for improvement. We worked with colleagues from NHS Greater Glasgow and Clyde and other national programmes to develop the programme with the aim of presenting a joined-up approach to improving care for older people and their families.

“Very motivational; very inspiring and worth doing again.”

“Best course I’ve been to. Very thought provoking.”

The event was a catalyst for change locally and has led to greater willingness and confidence about changing practice to improve care. According to Geraldine Marsh, Lead Nurse in the department of medicine for the elderly and physical disability, staff in the Langlands Unit had already begun to make small changes, but the event gave them confidence to implement improvements and call on the OPAC team for support.

“There was a real benefit to the event being local because it involved people who don’t usually get to these big events; staff nurses, students, consultants, AHPs and clinical support workers. People realise that if they have a good idea but are not sure about it, they can contact the OPAC team for information about what they could try and what has worked elsewhere. Working with OPAC has given people permission to change. Two years ago, staff would have resisted change if it wasn’t NHS board policy.”
Now, in an extension of the improvement work, the Langlands Unit is creating ‘exemplar’ wards where improvements will be identified and evaluated before being rolled out across the department of medicine for the elderly and further afield. Recognising that delirium is an important cause of falls, the 4AT assessment tool has been incorporated into the falls bundle allowing the DME staff to target patients at higher risk of falls.

The main advantage to working with the OPAC team has been its role as a conduit for sharing learning and a source of credible expertise, giving staff confidence that they are on the right track and have support.

“Working with the OPAC team has made staff realise they are there to help - Senior Charge Nurses now have more confidence to explore new ideas.”

– Lead Nurse, NHS Greater Glasgow and Clyde
NHS Shetland: Ensuring a systematic approach to delirium

The OPAC programme in NHS Shetland has raised awareness of delirium and frailty and ensured that good practice has become systematic. Following a national improvement event, the delirium assessment tool and TIME bundle were introduced in March 2013 to the 22 bed general medical admissions unit at the Gilbert Bain Hospital, Lerwick. By March 2014, the unit was 85% compliant with implementing the TIME bundle.

Many of the elements of the delirium pathway were already being implemented, but not in a systematic and formalised way. Senior Charge Nurse Jane Astles explained:

“Take incapacity forms, for example. We have been doing these since they came in but not necessarily for every patient who came in confused. Now we have a system in place where we are actively looking for confusion so we get the incapacity forms filled in straight away.”

The OPAC documentation, guidance and tools have been particularly useful for new staff because they highlight what should be considered and addressed, and also record the process.

The OPAC programme has “transformed perceptions” of the ward team’s work, improving recognition of its value and so increasing the team’s access to additional resources when required to look after patients with complex needs.

“It helps me see it’s not just about getting the care plans individualised, or making sure the medical staff do the AMTs, it’s about following through and linking it all together. It allowed me to take a step back from worrying about whether we’ve done the paperwork to see that we were delivering good care and evidencing it.”
NHS Highland: Delirium assessment at Caithness General Hospital

In July 2013, NHS Highland began a project to pilot the 4AT delirium assessment tool and TIME bundle for patients over the age of 75 at Caithness General Hospital. The pilot covered a 26 bed acute medical ward and an 18 bed care of the elderly, assessment and rehabilitation ward. Before the pilot started, assessment for delirium was patchy as Associate Lead Nurse and hospital redesign lead Pam Garbe explained:

“Delirium assessment was not part of the nurses’ role. The AMT tool was being used but not routinely, nor within six hours of admission. There was no real recording of delirium diagnosis in patients’ notes and it was possible that referrals were delayed because there was no pathway. 4AT was not used at all.”

The first step was to train staff in the use of the tool and to increase awareness of delirium, its risks and consequences. Once the 4AT tool was in place, its use was reviewed weekly and assessment increased in both wards (see below). Use of the 4AT tool in these two wards was quickly embedded and continues at a high level. In addition, from experience of using 4AT in the two pilot wards, the delirium assessment tool is now used routinely within six hours of admission in all wards in the hospital.
The two pilot wards also implemented the delirium TIME bundle if a patient’s 4AT score was raised. In the assessment and rehabilitation ward, once the patient’s baseline 4AT score was established, assessment was repeated if there was any change in the patient’s condition. Case studies played an invaluable part in training and helped ward staff understand the value of using the 4AT tool. This led the Caithness team to adapt the 4AT form included in patients’ notes to allow recording of repeat scores. Staff could then see at a glance if the 4AT score was increasing or decreasing.

The project resulted in quicker diagnosis of delirium, allowing earlier treatment and referral to the older adult mental health team where necessary. Staff now have powerful tools and a way to express concerns as part of their SBAR (Situation, Background, Assessment, Recommendation) report which means everyone is using the same language to describe a patient’s condition.

Shortly after introducing the TIME bundle, a trial of the Sepsis 6 pathway also began in the acute medical ward. The pathway ensures all the appropriate tests are done quickly, allowing rapid diagnosis and treatment so preventing further deterioration. However, as 4AT was not included in the Sepsis 6 pathway, patients admitted through A&E or straight to the acute ward and starting on the pathway, were not initially being assessed for delirium. After comparing the common elements of the Sepsis 6 pathway and the delirium work, NHS Highland decided to include 4AT in the Sepsis 6 pathway as a recognised and reliable tool. Extending the use of 4AT to a different pathway and different settings in this way improved the monitoring and assessment of acute patients. This was the first step in embedding 4AT throughout the hospital. In recent months, staff have begun to use Learn from Experience cards routinely and implementation of the ‘E’ element of the TIME bundle is improving.

For the future, use of both 4AT and the TIME bundle will be extended to all three acute sites in NHS Highland. There is also interest in piloting the tools in care homes and community hospitals, as early detection or prevention of delirium may avoid subsequent hospital admission.

Extensive training has been carried out since the project started in 2013, and this, coupled with the role of the dementia champions, means that staff are much more aware of dementia and delirium.

“We’re quite remote here, but we didn’t feel it because we knew what was happening through OPAC, whether it was in the islands or the central belt. Other teams were coming up with really good ideas and that makes you think.”

– Staff Nurse, NHS Shetland
What have we learnt?

These case studies outline some of the results NHS board teams have achieved so far. Elsewhere, the programme is changing admission and planning processes, improving engagement with families, reducing falls and length of stay, and saving time and resource. In NHS Forth Valley, for example, a new rapid access frailty clinic is improving the flow of patients through the hospital. The frailty pathway in NHS Fife has increased the focus on falls and delirium leading to more effective care planning. Meanwhile, NHS Tayside and NHS Grampian established an older people’s collaborative to support their improvement activity. The collaborative helped reduce complaints, gave staff the skills to identify delirium and created opportunities for medical student projects which generated useful recommendations for further improvements.

In NHS Ayrshire & Arran, teams are working on both the frailty and delirium components of the programme, lengths of stay have fallen and staff report that their experience of working in older people’s care is better. In a national recognition of their achievements, the Frail Older Person’s Pathway work at University Hospital Crosshouse was awarded the prestigious 2014 Integrated Care for Older People Scottish Health Award. More detail about this work is available in the *Improving the identification and management of frailty: A case study report of innovation on four acute sites in NHSScotland.*

[www.knowledge.scot.nhs.uk/improvingcareforolderpeople/resources.aspx](www.knowledge.scot.nhs.uk/improvingcareforolderpeople/resources.aspx)
Next steps

Healthcare Improvement Scotland is committed to:

- continuing to work with NHS boards to build capacity in improvement skills in order to build on achievements to date
- continuing to provide support to NHS staff to share learning and good practice to improve care for older people
- continuing to work with other national improvement programmes, such as Focus on Dementia, Person-Centred Care and Patient Safety to ensure a connected and consistent approach to the improvement of care for older people in acute care
- testing a new approach to provide targeted improvement support to three NHS boards to increase opportunities to share and spread learning locally
- sharing learning with NHS boards at national and regional learning events
- identify opportunities for improvement support identified through OPAH inspection processes, and
- ongoing collaboration with Scottish Delirium Association.
Project timeline

- Critical assimilation and analysis process
  - Critical friends meeting
  - Consultation with stakeholders
  - NHS board engagement event to agree themes and priorities
  
  April – June 2012

- Refine priorities and set specific aims
  - Clinical and NHS board engagement
  - Identify test sites and examples of good practice
  
  July – September 2012

- Innovation event
  - WebEx meetings with test sites
  - Identify critical measures of success
  - Assessment tools design, development, testing and refining
  
  September 2012

- Frailty assessment tool development
  - TIME bundle development
    (identification and management of delirium)
  
  September – December 2012

- Frailty screening consensus building workshop
  - Two Improving Care for Older People sessions at the Person-Centred Health and Care learning event
  
  November 2012

- Delirium subgroup and Scottish Delirium Association collaboration
  - WebEx improvement clinics
  - Frailty workshop
  - Identify current screening and assessment tools for identification of frailty
  
  January – March 2013

- Identify current good practice in identification and management of delirium
  - Improvement planning and engagement event
  - WebEx improvement clinics
  - Begin testing of frailty screening tools and TIME bundles
  
  March – April 2013
<table>
<thead>
<tr>
<th>Event Description</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-Centred Health and Care learning event to share results and feedback from initial testing</td>
<td>May – September 2013</td>
</tr>
<tr>
<td>WebEx improvement clinics and test site feedback</td>
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<tr>
<td>Test site visits</td>
<td></td>
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<tr>
<td>National improvement planning event</td>
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<tr>
<td>Refinement and updating of delirium bundle and checklist</td>
<td>September – December 2013</td>
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<tr>
<td>Delirium report published</td>
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<tr>
<td>WebEx improvement clinics and test site feedback</td>
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<tr>
<td>Two sessions (frailty and engagement) at Person-Centred Health and Care learning event</td>
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<tr>
<td>Improvement planning and engagement event</td>
<td>January – March 2014</td>
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<tr>
<td>WebEx improvement clinics</td>
<td></td>
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<tr>
<td>NHS Tayside Think Delirium Week</td>
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<tr>
<td>Frailty report and delirium toolkit published</td>
<td>April – June 2014</td>
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<tr>
<td>Educational modules launched</td>
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<tr>
<td>Delirium and frailty sessions at Person-Centred Health and Care learning event</td>
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<tr>
<td>Southern General Hospital ‘Best care everywhere’ local improvement event</td>
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<tr>
<td>NHSScotland event - posters on frailty and delirium work</td>
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<td>King’s Fund</td>
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<tr>
<td>NHS Fife local improvement event</td>
<td>June – December 2014</td>
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<tr>
<td>Frailty scoping workshop</td>
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<tr>
<td>WebEx calls on Adults with Incapacity (Scotland) Act 2000</td>
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<tr>
<td>European Delirium Association workshop</td>
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</tbody>
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Online resources


# Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>4AT (4As test)</td>
<td>rapid assessment tool for delirium</td>
</tr>
<tr>
<td>AHP</td>
<td>allied health professional</td>
</tr>
<tr>
<td>AMT</td>
<td>Abbreviated Mental Test</td>
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<tr>
<td>CGA</td>
<td>comprehensive geriatric assessment</td>
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<tr>
<td>DME</td>
<td>department of medicine for the elderly</td>
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<tr>
<td>HIS</td>
<td>Healthcare Improvement Scotland</td>
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<tr>
<td>OPAC</td>
<td>older people’s acute care</td>
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<tr>
<td>OPAH</td>
<td>older people in acute hospital</td>
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<tr>
<td>PDSA</td>
<td>Plan, Do, Study, Act</td>
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<tr>
<td>SBAR</td>
<td>Situation, Background, Assessment, Recommendation</td>
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<tr>
<td>SECAT</td>
<td>surgical elderly care assessment team</td>
</tr>
<tr>
<td>TIME</td>
<td>Think/Triggers, Investigate/Intervene, Manage, Engage/Explore</td>
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</tbody>
</table>
The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.