Healthcare Improvement Scotland | Evidence
Advice, guidance and intelligence

Ageing and frailty

Standards for the care of older people

November 2024

NHS SCOTLAND

We are committed to advancing equality, promoting diversity and championing human rights. These standards are intended to enhance improvements in health and social care for everyone, regardless of their age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socioeconomic status or any other status. Suggested aspects to consider and recommended practice throughout these standards should be interpreted as being inclusive of everyone living in Scotland.

We carried out an equality impact assessment (EQIA) to help us consider if everyone accessing health and social care services will experience the intended benefits of these standards in a fair and equitable way. A copy of the EQIA is available on request.

Healthcare Improvement Scotland is committed to ensuring that our standards are up-to-date, fit for purpose and informed by high quality evidence and best practice. We consistently assess the validity of our standards, working with partners across health and social care, the third sector and those with lived and living experience. We encourage you to contact the standards and indicators team at his.standardsandindicators@nhs.scot to notify us of any updates that might require consideration.

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Introduction

These standards update and replace Healthcare Improvement Scotland's Standards of Care for Older People in Hospital (2015). They apply in all settings where older people living with frailty receive health and social care. They provide a benchmark for progress towards nationally consistent integrated frailty services that put people and their rights at the centre.

Frailty

When a person is living with frailty, their body gradually loses its in-built reserves. This leaves them vulnerable to changes in their health or circumstances and makes it harder to recover from an injury, infection or illness.[1] People with frailty may experience falls, immobility, delirium, incontinence and are more susceptible to side effects of medication.[2, 3] As a person's frailty increases, they may find it more difficult to live independently and require additional support and care.[4] They are more likely to be admitted to hospital.[5]

Older people living with frailty are amongst the most vulnerable in our society. They can be at risk of harm if we do not understand and address their needs, or if our systems and services are inadequate, ineffective or poorly coordinated.[3] Frailty is not an inevitable consequence of ageing. Coordinated multiagency care supports and enables people experiencing frailty to remain as independent as possible.[6] If frailty, or likelihood of frailty, is identified early, it can sometimes be prevented, reversed or slowed down.[7]

Population to be covered by the standards

These standards are for people who are living with age-related frailty. Older people living with frailty are likely to benefit from integrated, multiagency planning and delivery of care.[8]

The United Nations defines an older person as someone above the age of 60. In the UK, 65 is traditionally used as the marker for the start of (chronological) older age. Biological ageing refers to the changes to a person's body and mind that occur over time. While chronological age cannot be modified, biological ageing can be impacted by a range of factors. These include a person's long-term health conditions, comorbidities, socioeconomic circumstances and lifestyle.[3] A person's biological age can better help predict how frailty may develop and impact them.[9]

Principles and aims

These standards promote positive, healthy and active ageing. In line with the principles of Realistic Medicine, the standards are underpinned by the following key principles:

- services should have a focus on prevention and early intervention
- people's choices and what matters to them should be at the centre of discussions
- interventions should be the least intrusive or restrictive possible.

The overall aim of these standards is to ensure national consistency in the quality of care that people receive. The standards aim to support national improvements towards integrated frailty services.

In meeting the standards, organisations will ensure that people:

- have the care and support they need to maximise enjoyment of life
- have choice, autonomy and ownership of their life
- work in partnership to make decisions about their health and care based on what matters to them
- experience a palliative care approach that helps them to live well with deteriorating health.

Policy context

These standards are underpinned by human rights and seek to provide better outcomes for older people with frailty. The United Nations Principles for Older Persons were adopted by the UN General Assembly (Resolution 46/91) on 16 December 1991. Governments are encouraged to incorporate human rights into their national programmes whenever possible. The 18 principles can be grouped under five themes: independence, participation, care, self-fulfilment and dignity.[10]

The ageing and frailty standards should be read alongside:

- Adults with Incapacity (Scotland) Act 2000[11]
- Dementia Strategy – Dementia in Scotland: Everyone's Story (2023)[12]
- Discovering meaning, purpose and hope through person centred wellbeing and spiritual care: framework[13]
- General Comment No. 22 from the UN Committee on Economic, Social and Cultural Rights[14]
- Getting it right for everyone principles (GIRFE)[15]
- Health and Care (Staffing) (Scotland) Act (2019)[16]
- Health and social care standards: my support, my life[17]
- Health and Social care: data strategy[18]
- International Covenant on Economic, Social and Cultural Rights[19]
- My Health, My Care, My Home – healthcare framework for adults living in care homes.[20]

- Palliative Care Matters for All: Working together to improve life, health and care for people of all ages living with serious illnesses and health conditions or dying in Scotland[21]
- Realistic Medicine - Taking Care: Chief Medical Officer for Scotland annual report 2023 to 2024[22]
- United Nations Convention on the Elimination of Discrimination Against Women[23]
- United Nations Convention on the Rights of Disabled People[24]

Implementation

The Healthcare Improvement Scotland Quality Management System (QMS) Framework supports health and social care organisations to apply a consistent and coordinated approach to the management of the quality of health and care services. By using standards as part of a quality management system, organisations can work in partnership to develop learning, plan improvement and understand their whole system. Central to this is the relationship between people, their care partners and organisations.

Healthcare Improvement Scotland (HIS) leads national improvement work focussing on frailty. In 2022, we published the findings of a 90-day learning cycle on frailty.[25] This involved a scan of the published literature on frailty and interviews with people with lived experience as well as health and social care professionals specialising in frailty. The report described seven core components of an integrated frailty system.

Following this, the Focus on Frailty improvement and implementation programme was launched. The programme aims to improve the early identification and assessment of frailty with a view to improving access to person-centred and coordinated health and social care services. We also host a national frailty learning system with over 1,500 members. Through the learning system, members share practice examples, tools and resources relating to frailty improvement work.

The ageing and frailty standards will support the spread of person-centred approaches to care and support for people living with frailty. The standards will also support improvements to the early identification and assessment of frailty.

HIS may use these standards in a range of assurance and inspection activities. They may be used to review the quality and registration, where appropriate, of health and social care services.

Format of the standards

All HIS standards follow the same format. Each standard includes:

- an overarching standard statement
- a rationale explaining why the standard is important
- a list of criteria describing what is needed to meet the standard
- what the standard means if you are an older person living with frailty
- what the standard means if you are a member of staff
- what the standard means for organisations
- examples of what meeting the standard looks like in practice.

Terminology

Wherever possible, we have used generic terminology that can be applied across all health and social care settings. The terms 'people,' 'person' or 'individual' are used within the criteria to refer to the person receiving care or support.

Care partner refers to any person or representative the individual wishes to be involved in their care. This may be a friend, neighbour, family member or other person who may provide informal help or support.

Unpaid carers provide or intend to provide care for an individual and their role is recognised under the Carers (Scotland) Act 2016.[26]

Staff refers to people who are employed to provide health and care support to an individual. It includes those defined in the Health and Care (Staffing) (Scotland) Act 2019.[16]

Palliative care is an approach that improves the quality of life of people who are living with one or more advanced or progressive health conditions. Palliative care prevents and relieves suffering through the early identification, assessment and management of pain and other problems–whether physical, mental health, social or spiritual.

Future care planning is about supporting adults and children, their families and carers, to think and plan ahead for changes in their life, health and care. It is an ongoing process that helps people talk about what matters to them in their lives, including if their health or care should change. Future care planning gives people opportunities to discuss realistic options for treatment and care. A personalised future care plan is recorded, shared and reviewed.

Organisation refers to all health and social care providers or services that support older people with frailty. This includes hospitals, primary care, community healthcare facilities, hospices, Hospital at Home services and care homes. It also includes independent health and social care providers.

Summary of standards

Standard 1: Identification of frailty

Organisations have systems in place to identify older people living with frailty at the earliest opportunity.

Standard 2: Assessment and future care planning

Older people living with frailty experience coordinated multidisciplinary support that is responsive to changes in their life, health and care.

Standard 3: Unpaid carers and care partners

Unpaid carers and care partners are valued, supported and trained to continue providing care.

Standard 4: Keeping active

Older people living with frailty are supported to keep active to maintain and improve mobility, independence and function.

Standard 5: Nutrition and hydration

Older people living with frailty are supported to eat and drink and receive specialist input if required.

Standard 6: Bladder and bowel health

Older people living with frailty receive early assessment and proactive management of bladder and bowel issues.

Standard 7: Medicines management and review

Older people living with frailty are prescribed medicines which are safe, effective and person centred.

Standard 8: Living and dying well

Older people living with frailty are empowered to live well throughout their life, maximise enjoyment and die comfortably.

Standard 9: Mental health and mental wellbeing

Older people living with frailty have their mental health needs addressed.

Standard 10: Sudden deterioration and immediate care

Older people living with frailty who experience a sudden change in their health can access timely, coordinated and consistent support.

Standard 11: Care in hospital

When in hospital, older people living with frailty receive safe, effective and person-centred care.

Standard 1: Identification of frailty

Standard statement

Organisations have systems in place to identify older people living with frailty at the earliest opportunity.

Rationale

Identifying frailty early enables timely interventions that can significantly improve a person's quality of life. Early detection of frailty in the community or hospital setting should lead to preventative measures, such as promoting physical activity and good nutrition.[27] This proactive approach can reduce the risk of falls, hospitalisations and other complications associated with frailty.[28, 29] Early identification facilitates personalised care planning and discussions about accessing social care support. Early identification also supports future care planning and care around death.[6, 29]

Large-scale identification of frailty can be used to plan services at a strategic level. Tools such as the electronic Frailty Index (eFI) use routine health record data to calculate a score based on a predicted frailty level.[30] Electronic population-based risk stratification can identify people who are likely to be living with frailty.[31] It should be used alongside tools such as a clinical frailty scale to evaluate frailty on an individual basis.[6] Identifying and confirming the level of frailty that someone is living with in any setting should support timely access to further assessment, investigations, treatment and coordinated care.[27, 32, 33] Identification of frailty should be undertaken in line with Standard 10.

Digital technology, including artificial intelligence, can help identify and manage frailty.[34] As technology advances, organisations should ensure that it is used appropriately and ethically.[35, 36] This includes artificial intelligence, large-scale data modelling and digital information systems. [18, 37-39] Organisations should work in partnership to test and evaluate screening and identification tools appropriate to different care setting.

Organisations should identify care partners and unpaid carers who may be providing practical day to day support. This supports assessment of their own care needs and what might happen if they were unable to continue providing care.[40, 41]

Criteria

1.1 Organisations use population-based risk stratification tools to:

- identify the prevalence and characteristics of frailty in their population
- inform strategic planning, including workforce planning
- implement effective prevention and healthy active ageing policies
- proactively offer early intervention and prevention activity to individuals.

1.2 Organisations proactively identify frailty in individual older people who they are aware have:

- experienced a significant change in their health or care
- moved between health and social care services.

1.3 Organisations identify frailty using an approach that is:

- based on current evidence of risk factors for frailty
- validated or recommended by professional organisations
- relevant to the care setting.

1.4 Staff are trained and knowledgeable about the use of clinical frailty scores in all health and care settings.

1.5 Organisations have processes in place to proactively identify frailty in older people in the community who experience:

- unintended weight loss
- falls
- changes in their cognition or memory
- fatigue and muscle weakness
- reduction in mobility or activities of daily living
- bladder and bowel issues.

1.6 Hospitals screen for frailty as part of all assessment, attendance and admission processes.

1.7 Dementia is identified as early as possible and confirmed through:

- brief cognitive tests, where indicated
- neuroimaging, where indicated
- collateral history (eg from unpaid carers or care partners)
- clinical examination.

1.8 Unpaid carers and care partners of older people with frailty are identified as part of initial screening and assessments and offered support.

1.9 Information gained from frailty screening is recorded and shared securely with:

- the person
- appropriate staff and agencies across the health and social care system
- unpaid carers or care partners as appropriate.

What does the standard mean for people?

- Organisations will be able to identify and respond early to changes in your health.
- You will be offered care and support that is right for you as early as possible.
- The people who help you will be identified and supported as early as possible.

What does the standard mean for staff?

Staff, in line with roles, responsibilities and workplace setting:

- have knowledge and skills to identify frailty using validated tools
- proactively recognise and identify frailty in the people they care for
- share relevant information about people living with frailty with other health and care professionals
- identify unpaid carers and care partners and help them receive the support they need.

What does the standard mean for the organisation?

Organisations:

- work collaboratively to test and improve screening tools specific to their population
- provide staff with role-appropriate training in the identification of frailty
- ensure screening for frailty is routinely undertaken amongst relevant population groups
- ensure information about a potential diagnosis of frailty is shared appropriately to support multidisciplinary working.

Examples of what meeting this standard might look like

- System-wide use of clinical risk stratification, frailty scores and electronic Frailty Index (eFI) in relevant settings.
- National, regional and local improvement work on frailty screening tools and processes.
- Use of frailty screening during unplanned admissions to hospital.
- Data on frailty prevalence included in strategic commissioning plans.
- Evidence of data on frailty improvement used to inform strategic decision making.
- Participation in national forums for raising awareness of frailty.
- Identification flowcharts and decision making tools based on screening outcomes.

Standard 2: Assessment and future care planning

Standard statement

Older people living with frailty experience coordinated multidisciplinary support that is responsive to changes in their life, health and care.

Rationale

Local authorities and NHS boards must work together to plan and deliver services for older people.[42] Frailty services should be designed to support people to maintain independence and remain in the community as much as possible.[6] This requires a fundamental shift in culture towards proactive, preventative and integrated services.[17, 43, 44]

Planning for a person's care should begin at the earliest opportunity. After someone has been identified as living with frailty, they should receive an assessment to identify and address their health and care needs. Assessments should consider underlying and potentially reversible causes of frailty. They should be repeated when there are changes in health or social care needs or when the person is dying. This includes identifying and addressing sensory and communication needs.[45]

A Comprehensive Geriatric Assessment (CGA) is best practice for frailty assessments.[27, 46] It is a multidimensional and interdisciplinary diagnostic process designed to evaluate an older person's capabilities.[29] Using CGA may reduce hospital admissions and shorten the length of time a person stays in hospital.[46]

People should be supported to be involved as much as they choose in the care planning process. Where this is not possible, decisions should be based on the person's best interests and what matters to them. Staff should be trained and supported to have open conversations with people about the future if their health or capacity changes.

A single integrated care plan can ensure that information is available when needed. The care plan should be accessible to all those involved. This includes the person, their unpaid carer or care partner and all relevant staff. Information about a person and their health should be shared in line with national protocols to support multiagency working.[4] A single point of contact can coordinate referrals, movement between services or places of care, follow-up and review.[6] This ensures that people receive the care they need from the right people at the right time.

Criteria

2.1 Health and Social Care Partnerships have a clear, system-wide strategic vision for the integrated delivery of services for older people with frailty with the involvement of health, adult social care, public health, community and voluntary sector partners.

2.2 Health and Social Care Partnerships ensure there is:

- a dedicated multidisciplinary team responsible for the delivery and coordination of frailty services
- clear referral pathways to the multidisciplinary team from all relevant services.

2.3 Health and Social Care Partnerships design frailty services in partnership with older people, care partners and unpaid carers using an evidence-based and evaluated service codesign approach.

2.4 People who have been identified as living with frailty in all settings receive:

- a CGA or comparable assessment of their health and care needs
- clear and accessible information on the outcome of their assessment and what to expect in the future.

2.5 Care plans:

- are developed with the full involvement of people and, where they choose, their unpaid carers or care partners
- are easily accessible to the person and, if they choose, their unpaid carers or care partners
- are easily accessible to all relevant members of the team around the person.

2.6 People have one documented care plan detailing all relevant health and social care information including:

- information that the person wishes staff to know about them
- their personal goals and preferred outcomes
- the results of health assessments and any diagnostic tests
- social work support assessments if undertaken
- medication reviews and prescriptions
- discharge information from a service or hospital, if discharged
- plans for holistic care in the last days and weeks of life for the person and those close to them
- specific decisions about interventions and treatments in the future, including cardiopulmonary resuscitation
- adult support and protection concerns, where appropriate.

2.7 Older people and their unpaid carers or care partners are provided with:

- the name of a lead coordinating individual and agency or single point of contact
- details of the roles and responsibilities of key individuals or organisations involved in their care.

2.8 Care plans are reviewed or updated if there is a change in the life, health or circumstances of a person with frailty.

2.9 Staff are fully informed about:

- their roles and responsibility within the frailty pathway
- the meaning of frailty assessments or screening
- how to act on the results of frailty assessments or screening.

2.10 Staff have the training and support to participate fully in multidisciplinary team meetings and care planning.

2.11 Staff have the training and resources to meet the needs of people who may experience:

- behavioural and psychological symptoms of a cognitive impairment or dementia
- communication difficulties
- neurodiversity
- hearing or sensory loss
- emotional distress.

2.12 Older people with frailty receive information and support to set up power of attorney where this is their choice.

What does the standard mean for people?
• Assessments of your health, care and support will focus on what matters to you and what you would like to be able to do. • Information about your care will be written into one single plan that will be shared with you and the people who need to see it. • You will be supported to ask questions about what may happen in the future. • You can choose who should be included in discussions about you and your care. • Staff will support your privacy and confidentiality.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • undertake relevant frailty assessments and investigations where frailty has been identified • use information from frailty assessments to identify and discuss a person's current and future care needs • work effectively with other members of the multidisciplinary team • consider a person's experiences, values and priorities at all stages of care planning • recognise the importance of autonomy and the right of the individual to make informed decisions about their care • include any unpaid carers or care partners in discussions about a person's care as appropriate • have training and skills to support discussions about future care planning • know when and where to refer to further support for people living with frailty.

What does the standard mean for the organisation?
Organisations: • plan and develop integrated services that meet the needs of their population • support staff to work in partnership across a multidisciplinary team • provide effective mechanisms to support coordination across multiagency teams • provide mechanisms for staff to share and access relevant health and social care information • integrate future care planning with other care coordination or person-centred care planning processes • involve care partners in care coordination and future care planning where appropriate.
Examples of what meeting this standard might look like
• Use of tools and frameworks to support shared decision making during care planning. • Use of person-centred plans created and shared digitally where possible. • Clinical information shared as appropriate with multidisciplinary teams. • Future care plans that are recorded, shared and updated. • Assessment and identification protocols and procedures. • Accessible language in all documents and communication. • Use of communication aids and tools.

Standard 3: Unpaid carers and care partners

Standard statement

Unpaid carers and care partners are valued, supported and trained to continue providing care.

Rationale

The Carers (Scotland) Act 2016 defines a 'carer' as an adult or child who provides or intends to provide care for another individual. It does not apply to people who provide care under a contract or who are volunteers. Under the Act, unpaid carers have a right to be involved in decisions relating to a person's health, care and future.[26]

Unpaid carers may need support to look after their own health and wellbeing. This includes access to health assessments and information about practical support and peer support. It also includes information on how to access financial and social support for the person they are providing care for. Support for carers should be holistic, tailored and preventative.[26] Unpaid carers have a right to an Adult Carer Support Plan or Young Carer Statement. When general visiting restrictions are required for infection control purposes, people should still be able to receive visits from a nominated person.

Unpaid carers or care partners may be involved when a person does not have capacity. All healthcare staff should consider a person's capacity to consent to any health or care interventions. The Adults with Incapacity (Scotland) Act 2000 is used to protect the welfare of adults who are unable to make decisions for themselves.[47] It includes provisions for power of attorney. Power of attorney allows individuals to designate someone to make decisions on their behalf. Staff should understand the relevant legislation at a level appropriate to their practice. This includes understanding when and how they should involve people with power of attorney in decisions.

Criteria

3.1 Unpaid carers and care partners are:

- valued and respected
- included in decision making where appropriate
- supported to provide care for as long as they choose.

3.2 Unpaid carers are offered an Adult Carer Support Plan or Young Carer Statement.

3.3 Unpaid carers and care partners of people with progressive health conditions are supported to understand what to expect in the future.

3.4 Organisations support unpaid carers and care partners to access, as required:

- practical support and training, where appropriate
- psychological and emotional support
- short breaks from caring
- financial support.

3.5 Unpaid carers and care partners are fully informed about:

- care options, including how to access self-directed support
- any social security or other financial assistance they or the person they care for may be entitled to
- what it means to be granted power of attorney and how they can fulfil this role
- independent advocacy and how to access it.

3.6 Unpaid carers and care partners know how to raise concerns about a person's care or support and can access an independent complaints process if required.

3.7 Staff receive training appropriate to roles and responsibilities about adult support and protection, including:

- patterns of abuse and coercive control
- identification of an adult at risk of harm
- local safeguarding protocols and processes.

3.8 Unpaid carers and care partners are provided with the right information and support to assist people with frailty to keep active, reduce falls and prevent deconditioning where appropriate.

3.9 Unpaid carers and care partners are supported to understand people's changing nutritional and hydration needs and choices, particularly when the person they care for is very frail or dying.

3.10 Unpaid carers and care partners of people with dementia are provided with specialist support and information.

3.11 Unpaid carers and care partners are fully involved in discussions about care arrangements, treatment, interventions or future care planning where appropriate.

3.12 Organisations enable specified unpaid carers or care partners to visit even when general visiting restrictions are required.

What does the standard mean for unpaid carers or care partners?
• Your role will be recognised and supported. • You will be listened to and treated with respect as part of the care team. • Your own needs will be documented and met as much as possible. • A nominated person will always be able to visit the person you are looking after. • You will receive information about care options, and what might happen in the future. • If you have power of attorney, you will be able to discuss what this means with trained staff.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • understand the role of unpaid carers and care partners • support unpaid carers and care partners as required • involve people with power of attorney appropriately in decisions • know what to do if they consider that someone with power of attorney is not acting in the best interests of the person • involve unpaid carers and care partners in care coordination and future care planning where appropriate.
What does the standard mean for the organisation?
Organisations: • have systems and processes in place to identify unpaid carers and care partners • provide unpaid carers and care partners with the support they need, including access to an Adult Carer Support Plan or a Young Carer Statement • ensure policies and processes are in place to support the wellbeing of unpaid carers and care partners.

Examples of what meeting this standard might look like
• Evidence of good documentation of any unpaid carers and care partners within the clinical notes of an older person with frailty. • Carers' policy or strategy embedded into working practices. • Informal update of training and resources for care partners. • Evidence of carers' assessments. • Evidence of staff training and uptake of training on power of attorney.

Standard 4: Keeping active

Standard statement

Older people living with frailty are supported to keep active to maintain and improve mobility, independence and function.

Rationale

Keeping physically active and mobile can reverse or prevent frailty and falls.[48] People with frailty may experience a sense of achievement, satisfaction and confidence from physical activity.[49] People who maintain their mobility may experience a higher quality of life as they age.[50] People should be supported to engage in meaningful and purposeful physical activity and to do things that are important to them.[51-53] Individuals should be enabled and supported to make informed choices about movement and activity.[54]

Significant lack of mobility may lead to general deconditioning or specific conditions such as pressure ulcers. Deconditioning is a deterioration of physical and functional abilities. It can be caused by inactivity, bed rest or a highly sedentary lifestyle.[55] It can occur during periods of immobility, such as an acute illness, injury, surgery or hospital stay. Up to 65 % of older people experience a decline in function when they are in hospital.[55]

Sarcopenia is an age-related progressive loss of muscle mass, function and strength. People who live with sarcopenia are three times more likely to fall than people who do not.[56] A comprehensive assessment should be undertaken to reduce falls in older adults who are likely to experience a fall.[57]

Criteria

4.1 Organisations work together to:

- improve access to leisure activities and green space
- increase opportunities for people to engage in physical activity.

4.2 Organisations work together to ensure that older people with frailty can travel, access shops and facilities and maintain independence.

4.3 People can access community-based activities to improve balance, muscle strength and bone health.

4.4 People have access to services, technology and equipment to support independence and manage activities at home.

4.5 People with advanced frailty are supported to undertake physical activity based on their own values and priorities.

4.6 People are provided with accessible advice and information about:

- how to improve or maintain mobility, strength and balance
- how to reduce deconditioning
- their likelihood of falling
- setting physical activity goals that are important to them.

4.7 The care planning process includes a multidomain falls assessment[57] that covers:

- mobility
- sensory function
- activity of daily living
- cognitive function
- autonomic function
- medical diagnoses
- medication and polypharmacy
- nutrition and hydration
- risk of falls caused by the person's environment or footwear.

4.8 People who may be likely to fall are offered preventative interventions, where appropriate, which:

- reflect their goals and outcomes
- are delivered by a specialist multidisciplinary team
- maintain their skills and function
- include a community-based progressive exercise programme for a minimum of 12 weeks[57]
- include provision of equipment such as walking aids.

4.9 People who may be likely to fall are involved in discussions about:

- appropriate adaptations to the person's home (or care home)
- suitable care or living arrangements.

4.10 Staff are trained and supported to:

- promote and encourage mobility and independence in all care settings
- understand the psychological barriers to activity
- reduce the likelihood of falls
- reduce the risk associated with not moving
- provide tailored education on safer mobility.

4.11 Organisations ensure that policies and environments enable physical activity and movement.

4.12 People with frailty being considered for planned or elective surgery are offered advice and support on prehabilitation to maximise physical health before their operation.

4.13 People with frailty can receive a home assessment to optimise their independence and safety at home (or their care home).

4.14 Organisations invest in and provide access to technology to:

- enable people to maintain mobility and independence in the community
- encourage movement and activity
- provide data to reduce falls in the environment
- detect when a fall has happened
- enable the person to call for help.

What does the standard mean for people?
• You will be encouraged and supported to keep active as you age. • You will be supported to focus on daily activities and functional movement. • You will have a care plan to reduce the likelihood of falling. • You will be encouraged and enabled to be as mobile and independent as possible, including when you are in hospital. • If you have a fall, you will be offered appropriate support and rehabilitation.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • work with people to help them keep active • know the likely causes of falls • take proactive steps to prevent falls • have the right knowledge and experience to promote keeping active and encourage independence • undertake an assessment of a person's likelihood of falling and act on it • work in partnership across different sectors to reduce the likelihood of falls • know the impact of not moving and the risks associated with being sedentary for long periods of time • are aware of and follow referral pathways for rehabilitation across the Health and Social Care Partnership.
What does the standard mean for the organisation?
Organisations: • develop and review high quality, accurate information on safer mobility in a range of different languages and formats • demonstrate strong collaborative leadership to balance the safety of older people with the promotion of independence and physical activity • have processes and protocols in place to reduce the likelihood of falls • provide access to equipment to reduce the risk of falls and encourage safe movement • provide access to evidence-based interventions to reduce the risk of falls and encourage safe movement.

Examples of what meeting this standard might look like
• Referrals to community social activity groups such as walking groups. • Use of wearable technology, including step counters and activity trackers. • Implementation and development of dementia-friendly communities. • Evidence of balance and strength activities delivered in the community. • Audit of ambulance and community alarm calls related to older people experiencing falls. • Creative approaches to introduce meaningful activity. • Established multiagency pathways to physiotherapy, occupational therapy and rehabilitation. • Pathways in place to trigger a comprehensive review of potential reasons for falls. • Data on length of stay in hospital, falls and readmission rates as a result of falls. • Evidence of activity or rehabilitation plans.

Standard 5: Nutrition and hydration

Standard statement

Older people living with frailty are supported to eat and drink and receive specialist input if required.

Rationale

Eating and drinking have important social and cultural components. People should have the time and support to eat and drink. Their preferences and needs should be considered in all decisions about their nutrition and hydration. Good oral care ensures that older people with frailty can eat and drink in comfort.[58]

Hydration and nutrition can be impacted by social isolation, financial hardship and poor mobility. It is impacted by co-ordination or swallowing difficulties. People with a cognitive impairment or dementia may need support and prompts to eat and drink.[59] A person's dignity and rights should be upheld when they need help to eat and drink.[60] Diet, hydration and difficulty swallowing may also impact effectiveness of medicines.

The World Health Organization identified nutrition as essential for healthy ageing.[61] Poor quality of diet may lead to loss of muscle mass and immune or cognitive function. It may lead to unintentional weight loss and sarcopenia.[62, 63] Excess calories may also be associated with poor quality of diet.

Malnutrition is common in older people with frailty.[64-66] Up to one third of people over 65 requiring hospital admission and 40 % of care home residents are at risk of malnutrition.[67] Identifying malnutrition can have a positive effect on quality of life, recovery, rehabilitation, length of hospital stay and readmission rates.[64, 66, 68]

When someone is dying, they are likely to eat and drink less. They should be supported to focus on enjoyment of food and the social interaction associated with eating and drinking.

Criteria

5.1 Older people with frailty who experience unexplained weight loss, loss of appetite or symptoms of malnutrition are screened and referred, where required:

- for further diagnostics and investigations
- to specialist dietetic services
- to other relevant services.

5.2 People's care plans detail their nutrition and hydration needs including:

- eating and drinking likes and dislikes
- food allergies or intolerances
- cultural, ethnic or religious dietary requirements
- social and environmental mealtime requirements
- relevant physical measurements, such as weight, mid-upper arm circumference or grip strength
- swallowing difficulties
- the need for help or equipment to support eating and drinking
- the need for additional time when eating and drinking.

5.3 People at risk of malnutrition are:

- offered advice on nutrient-dense foods and drinks
- referred for dietary advice and specialist support in line with local NHS referral criteria.

5.4 People with swallowing difficulties are offered or referred to as required:

- modified texture of food and drink[69]
- alternative formulation, routes or dosing of medicines
- speech and language therapy
- support to overcome any physical or postural difficulties.

5.5 People are supported to eat with others, including their family or communities, if they wish.

5.6 Organisations ensure people can maintain good oral health by supporting people:

- with tooth brushing
- to keep their mouth clean and moist
- to access well-fitting dentures
- to access regular dental check-ups
- through referral to specialist dentistry if required.

5.7 Organisations have an 'eating and drinking with acknowledged risks' policy which is fully implemented and regularly reviewed.

5.8 Organisations signpost to partner and third sector agencies that offer specialist support and advice on food, nutrition and hydration.

What does the standard mean for people?
• Your choices and requirements about eating and drinking will be respected. • You will be supported with enough time to eat and drink. • You will have access to equipment that you may need to help you eat and drink. • You will be referred for dietary advice if you need it. • You will receive appropriate assessment and support if you have difficulties with eating, drinking or swallowing. • You will be supported to understand how what you eat and drink impacts on your physical health and wellbeing. • You will be supported to maintain good oral health.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • are trained to recognise and respond appropriately to signs and symptoms of malnutrition • are trained to recognise and respond appropriately to signs of dehydration • respect and support people's decisions related to their eating and drinking • support people to make informed decisions about clinically-assisted nutrition and hydration. • support people to maintain good oral health through tooth brushing and preventing dry mouth.
What does the standard mean for the organisation?
Organisations: • have processes to identify and address people's nutrition and hydration needs • have systems that support appropriate food choices, aiming to avoid malnutrition and dehydration • provide equipment and access to specialist input to support people to eat and drink • enable people to eat and drink with others if they wish • ensure that people have access to well-fitting dentures • have referral pathways to dentistry including specialist dentistry.

Examples of what meeting this standard might look like
• Protocols for nutrition and hydration screening and assessments. • Evidence of pathways for equitable access to specialist nutrition and hydration support. • Alternative menus to allow choices about food and drink. • Protected mealtimes with adequate time and support from unpaid carers and care partners. • Registries or databases of community activity groups and organisations which are kept up to date. • Provisions for the right adaptive equipment (such as plates, cups and cutlery) to enable people to be as independent as possible. • Toothbrushing and oral health care programmes in all settings. • Referral pathways to dentistry.

Standard 6: Bladder and bowel health

Standard statement

Older people living with frailty receive early assessment and proactive management of bladder and bowel issues.

Rationale

Bladder and bowel health is closely linked with frailty.[70] Good bladder and bowel health reduces the risk of infection.[71] It can also promote and maintain a person's independence, dignity and broader health and wellbeing. Good diet, fluid intake and keeping active are important for good bladder and bowel health.[72] Many bladder and bowel issues can be caused or impacted by medication. Medicines should be prescribed and reviewed in line with Standard 7.

Open conversations about bladder and bowel health can lead to early intervention. Staff should discuss any problems with sensitivity and compassion. The person's dignity should always be respected.[73]

Management of ongoing bladder or bowel issues should address the underlying cause.[71] People should have access to effective multidisciplinary treatment. The team should include a minimum of continence nurses and specialist physiotherapists. It may include urogynaecologists, urologists, colorectal surgeons and gastroenterologists who specialise in functional pelvic conditions.[71]

Systematic use of incontinence pads is often unnecessary. It can negatively impact a person's mental and physical health, independence and sense of identity.[74, 75] Products should be the right size and fit for the person. Urinary catheterisation can allow some people to manage incontinence, reduce the risk of kidney problems and promote independence. A catheter can be uncomfortable and may increase likelihood of urinary infection.[75] Having a catheter may affect self esteem and body image. It may impact sexual wellbeing and intimacy.

Constipation can have a significant impact on older people, sometimes leading to a range of physical, emotional and social issues including risk of delirium.[72, 76] It can cause discomfort and pain which in turn may discourage physical activity. People at risk of constipation should be given lifestyle and dietary advice. Laxatives should be prescribed regularly or as required in line with Standard 7.

Criteria

6.1 Organisations undertake health promotion activity to promote good bladder and bowel health.

6.2 Staff are trained and knowledgeable about:

- the importance of bowel and bladder health to wider health and dignity
- how to proactively and sensitively enquire about a person's bladder and bowel health
- routine management of continence issues
- how and when to refer to a relevant specialist.

6.3 Organisations ensure that bladder and bowel issues are addressed and recognised as part of routine care in all settings.

6.4 People with continence issues are supported:

- to access the assessment and treatment they need
- by knowledgeable and sensitive staff
- to be equal partners in decision making
- to manage their own care.

6.5 People receive an assessment of any issues they experience with their bladder or bowel and are involved in developing a plan for treatment or management. [71]

6.6 Organisations should have pathways and protocols for:

- the identification, assessment and treatment of constipation
- the insertion and removal of catheters
- the treatment of UTIs including antibiotic prescriptions
- regular review of medicines that may cause constipation
- preventative interventions for people experiencing bladder and bowel issues.

6.7 Catheters should be:

- avoided where possible
- used when safe and clinically appropriate to do so
- reviewed to ensure their use is safe and required
- removed as soon as possible.

6.8 When people require continence products:

- they are provided with fit-for-purpose continence products or equipment
- their needs are reviewed in line with changes to their health or care.

6.9 People receive laxatives as required if their medicines can cause constipation.

6.10 People receive timely access to antibiotics to treat urinary tract infection when they experience symptoms in line with current guidelines.

What does the standard mean for people?
• You can discuss any concerns you have about your bladder or bowel with sensitive and supportive staff. • Staff will identify and treat any underlying causes for your bladder or bowel issues. • Your bladder or bowel issues will be proactively managed and treated where possible. • You will be provided with continence products that are right for you if you need them.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • promote and enable good bladder and bowel health • discuss people's bladder and bowel function in a sensitive way • involve people in discussions about the management of bladder and bowel issues • ensure people have continence products that are fit for purpose • refer people for specialist continence support where required.
What does the standard mean for the organisation?
Organisations: • provide access to timely assessment and management of continue issues and access to equipment • have processes in place to support the identification, assessment and treatment of constipation • have process and pathways for safe insertion and removal of catheters.

Examples of what meeting this standard might look like
• Evidence of routine enquiry about people's bladder and bowel issues. • Referral pathways to specialist continence teams. • Evidence of treatment and management plans for bladder and bowel issues. • Risk assessments for catheter use. • Provision of continence products in the right size.

Standard 7: Medicines management and review

Standard statement

Older people living with frailty are prescribed medicines which are safe, effective and person centred.

Rationale

People living with frailty often have multiple long-term health conditions that require medicines. They should be fully informed about what they have been prescribed, including its purpose, benefits and side effects. People can make an informed choice not to take medicines and this should be respected. Where a person without capacity refuses essential medicines, medicines may be given in a disguised or covert form.[77] The use of covert medication is governed by the Adults with Incapacity (Scotland) Act 2000. Covert medication must only be used in line with these guidelines.[78]

People living with multiple long-term health conditions are likely to take multiple medicines. This can increase the likelihood of falls, delirium, bladder and bowel issues and other side effects.[79] A seven-step polypharmacy review should be considered where appropriate.

Medicines are associated with risk of falls.[80] High risk medicines, including anticholinergics, are associated with adverse outcomes.[81] Reviewing and stopping unnecessary medicines may improve a person's quality of life and reduce anxiety, pain and low mood.[82] It can contribute to broader public health goals and reduce waste. Non-pharmacological approaches should be considered where possible.

The principles of Realistic Medicine should be considered when prescribing and stopping medicines. The use of BRAN (benefits, risks, alternatives and what happens if you do nothing) questions can support people to be involved in decisions and reduce harm.[83] Medicine reviews should consider a person's whole circumstances. This includes their choices and preferences.[84]

Unplanned gaps or suddenly stopping medicines may lead to harm and distress. People should have access to their medicines when moving between health or care settings. People may store more than they need due to confusion or fear of running out. This can result in out-of-date medicines and harmful drug interactions. Medication compliance aids can be valuable for older people with cognitive impairments. However, people using them may experience difficulty when a medicine changes or is prescribed on an 'as required' basis.

Anticipatory or 'just in case' medicines can be prescribed in advance for individuals who are likely to die in the next few weeks. These injectable medicines are used to manage symptoms that can happen when someone is dying. Planning ahead when someone is dying avoids delays in managing symptoms especially at night or weekends.

Criteria

7.1 People are involved in conversations about medication options that includes a discussion on:

- the benefits
- the risk of side effects or medication-related harm
- alternatives to medicines
- the likely outcome of not prescribing the medicine.

7.2 People are supported to:

- discuss their medicines, including experience of side effects and any concerns they have, with an appropriately trained professional
- store, manage and administer their medicines in a way that is right for them
- set targets for pain and chronic disease management, in partnership with healthcare professionals
- understand the purpose of their medicines
- take their medicine within the principles of informed choice.

7.3 Unpaid carers and care partners and receive information about:

- medicines and possible side effects
- ongoing monitoring
- alternatives to medicines
- how to support the person to take their medicine
- storing medicines and when to use medicine compliance aids
- any changes to medicines and the reason for the change.

7.4 Organisations have a covert medication policy that is in line with up-to-date guidance and legislation.

7.5 High risk medicines are reviewed regularly and stopped where appropriate.

7.6 Older people with frailty regularly receive a person-centred medicines review led by a pharmacist, with input from a multidisciplinary team where appropriate.

7.7 Staff have the knowledge and skills to:

- safely stop medicines in line with current guidance
- refer to specialists for a review of medicines outwith their competence.

7.8 A seven-step polypharmacy review should take place:

- for people with multiple chronic conditions
- for people taking multiple medicines
- when there are significant changes in health status, such as new diagnoses or hospital admission
- when there are changes to the person's medicines
- whenever the person, or their unpaid carer or care partner, expresses concerns about a medicine or side effects.

7.9 Changes to a person's medicine is documented and communicated across the multidisciplinary team and with the person and their unpaid carer or care partner.

7.10 During transition between care settings and at time of discharge, organisation ensure people have:

- medicines in their original packs where appropriate
- new medicines in the most appropriate quantities
- at least a seven day supply of their usual medicine.

7.11 When a person is dying, the person and their unpaid carers or care partners are involved in decisions about stopping unnecessary treatments and monitoring.

7.12 When staff recognise a person is dying, anticipatory medicines are prescribed and available, whether the person is being cared for at home, in a care home or in a hospice or hospital.

What does the standard mean for people?
• You will be supported to understand what your medicine is for and any side effects you may experience. • You will be able to access the correct medicine in the correct form when you need it. • Your medicines will be reviewed if there are changes in your health, life or care. • You will have the opportunity to discuss the risks and benefits of any medicines. • You will be supported to take your medicines. • If you are on many different medicines, these will be reviewed to check they are still right for you. • The people who care for you will have the information and guidance they need to support you to discuss and take your medicines.

What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • prescribe medicines in line with best practice and current guidelines • ensure people are able to make informed choices about their medicines and supported to take and store them • have an awareness that older people with frailty are more likely to experience side effects from medicines • know which medicines may cause withdrawal symptoms if stopped abruptly • conduct regular medication reviews using a structured approach.
What does the standard mean for the organisation?
Organisations: • demonstrate a good understanding of medicine reconciliation, polypharmacy reviews and a Realistic Medicine approach to prescribing • have systems and processes in place to identify, undertake and action recommendations from seven-step polypharmacy reviews • provide training and support to staff undertaking medication reviews.
Examples of what meeting this standard might look like
• Evidence of structured polypharmacy reviews with appropriate documentation and coding. • Covert medications policies. • Audit on the provision of 'just in case' medicines for people who are dying. • Evidence of pathways and processes for medicines reconciliation. • Use of electronic systems and other systems and processes for example Hospital Electronic Prescribing Medication and Administration, Medication Administration Recording and Requesting.

Standard 8: Living and dying well

Standard statement

Older people living with frailty are empowered to live well throughout their life, maximise enjoyment and die comfortably.

Rationale

Frailty can change a person's sense of self. It can affect how they are perceived and treated by others, including health and care staff. Feeling valued, respected and able to take part in meaningful activities can help maintain a person's quality of life. This can prevent or delay when they might start to experience significant health or social care needs.[85] People should be supported and enable to live well, make choices and do things that matter to them as they grow older.

Engaging in mentally stimulating activities can help reduce the risk of cognitive decline and neurodegenerative diseases including dementia.[86] Staying mentally active enhances overall brain health, promotes independence and improves quality of life. Maintaining and promoting good brain health involves following a healthy diet, spending time with other people, reducing alcohol intake, getting sufficient sleep and taking regular exercise.[87, 88] Social connection and activity, has a positive impact on cognition and may delay the onset of dementia.[89]

Older people with frailty may have thoughts and questions about their future.[90] They can benefit from opportunities to talk about their lives including death, dying and loss, spiritual or cultural matters and what is important to them. Staff that are trained and supported to have open and compassionate conversations with people can help them have these discussions as their health declines. This includes the possible outcomes or benefits of further tests or treatments and how they may align with a person's values.

Palliative care, which focuses on the person's quality of life, should be provided along with other treatments and care as people become more frail. People who are dying should have pain or other symptoms well managed to keep them comfortable. This includes prompt access to necessary equipment and medicines. Support for unpaid carers and care partners should not stop at the point of death. They should continue to receive compassionate and effective bereavement support in line with the Scottish Bereavement Charter.[91]

Criteria

8.1 Organisations support people to access activities which maximise their physical health, social, spiritual and mental wellbeing.

8.2 People are supported to make informed choices about risks in their lifestyle and activities they enjoy.

8.3 People have access to essential daily care, where required, including:

- maintenance of skin integrity
- maintenance of good personal hygiene
- care of teeth and dentures
- technology and equipment to manage hearing and sight loss.

8.4 People are provided with resources to support their brain health including information and support on:

- improving sleep
- staying connected
- stopping smoking
- reducing alcohol intake
- managing blood pressure.

8.5 Organisations work with partners and third sector agencies to signpost or refer to community-based services to prevent and reduce social isolation.

8.6 People are offered advice and support to manage symptoms such as pain, breathlessness, fatigue, anxiety or poor appetite.

8.7 People living with frailty feel safe, involved and well cared for in their care environment.

8.8 People are enabled and supported to have:

- honest, compassionate conversations about living well with deteriorating health
- early discussions about palliative care and the holistic support available for them and their unpaid carers or care partners
- conversations about what happens when they are dying
- information about care and treatment options when they are dying.

8.9 Unpaid carers and care partners can access support and information about anticipatory grief, grief and bereavement support.

8.10 People who are dying are involved in developing an holistic assessment of their needs and receive responsive, personalised advice, care and support.

8.11 Future care plans are:

- reviewed and updated as required in the final days or weeks of life
- communicated with everyone involved in a person's care.

8.12 When a person with frailty is dying, this is openly acknowledged and staff offer sensitive and compassionate support in line with their values and wishes.

8.13 Staff have 24/7 access to advice from specialist palliative care services when someone is dying at home, in a care home or in hospital.

8.14 Organisations provide bereavement education, training and support for staff including peer support and signposting to support services if required.

What does the standard mean for people?
• Your life and how you want to live it will be maintained as long as possible. • You will receive the support and care you need for daily activities and things that are important to you. • You will be supported to maintain your social networks, activities and contact with your local community. • If your health declines, you will be supported in ways that matter to you. • If you are dying, you will be cared for in ways that mean you are comfortable and safe, with the people that matter to you close to you. • You can talk to staff about death and dying if and when you wish to.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • support people to live their lives as well as possible • are able to talk with people about healthy living and wellbeing as well as declining health, loss, dying and death • signpost or refer to voluntary and community initiatives which promote a person's wellbeing • recognise and respond to the cultural and spiritual needs of people living with frailty from diagnosis to death and bereavement • recognise when a person is dying • provide sensitive and compassionate palliative care.

What does the standard mean for the organisation?
Organisations: • plan and design services to promote wellbeing • enable daily activities that matter to people • actively promote effective relationships between statutory and voluntary organisations, communities, public bodies and other agencies that facilitate wellbeing for older people living with frailty • have referral pathways to specialist palliative care across all settings.
Examples of what meeting this standard might look like
• Use of mental wellbeing screening and scores to measure effect of wellbeing support interventions. • Documenting referral onto other agencies to support wellbeing. • Commissioning data for community wellbeing and healthcare services. • Commissioning data for community support services promoting wellbeing and social connection. • Evidence of social prescribing. • Update of staff training including bereavement support relevant to their roles. • Adoption of the Scottish Bereavement Charter.

Standard 9: Mental health and mental wellbeing

Standard statement

Older people living with frailty have their mental health needs addressed.

Rationale

Mental health is a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well. It is about life satisfaction, optimism, self esteem, feeling in control, having a purpose and a sense of belonging and support.[93] Social isolation and loneliness is associated with physical health conditions such as cardiovascular disease and stroke.[94] Preventative activity to improve and maintain brain health and mental wellbeing should be considered in line with Standard 8.

Older people with frailty may experience depression, loneliness and low levels of satisfaction and wellbeing.[95] As people age, they may need support to adapt to changes in their life and health. Declining health and loss of abilities may affect a person's mental wellbeing and their engagement with the world and with others.[13] Pain, illness, falls, lack of energy and loss of memory may challenge a person's sense of identity, meaning and purpose. Anxiety in older people is more likely to be undiagnosed or normalised. It is linked to adverse health outcomes.[96] Validated tools should be used to screen for mental health conditions in older people with frailty.

Dementia impacts mental health by affecting cognitive function and emotional wellbeing. People living with dementia may experience cognitive decline, mood changes and behavioural issues including aggression and hallucinations.[97] This can lead to social isolation and increasing feelings of loneliness and depression. People who have been diagnosed with dementia should be offered specialist support for a minimum of 12 months.[98]

Some people grow old with enduring mental health conditions. A small number of people develop these conditions later in life. People with long-term mental health conditions should have access to psychiatry through specialist referral pathways.

Criteria

9.1 Organisations have processes to identify and respond to stress and distress, confusion and anxiety.

9.2 Staff use validated tools to assess the mental health needs of older people with frailty.

9.3 People's mental health needs are documented in their care plan and shared with the person, their unpaid carer or care partner and relevant staff.

9.4 People receive postdiagnostic support for a minimum of 12 months following a diagnosis of dementia.

9.5 Frailty pathways include acute mental health support during crisis to ensure older people with frailty are looked after in the right place.[99]

9.6 People with long-term or enduring mental health conditions have equitable access to physical health interventions to manage frailty.

What does the standard mean for people?
• Your mood, mental health and psychological state will be recognised, assessed and cared for. • Staff will take account of any mental health or psychological issues you have when they are caring for you. • You will be referred for specialised mental health care if you need it.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • routinely assess the mental health of older people living with frailty • refer people to mental health services as required • work with specialist mental health teams to support older people with frailty.
What does the standard mean for the organisation?
Organisations: • have systems and processes in place to identify and respond to the mental health needs of older people with frailty • have referral pathways to specialist input where required.
Examples of what meeting this standard might look like
• Waiting time for specialist psychiatry input. • Referral pathways to mental health treatment. • Implementation of mental health standards. • Consistent screening of mental wellbeing and mental health conditions. • Evidence of meaningful activities and engagement strategies to reduce stress and distress in people living with delirium or dementia.

Standard 10: Sudden deterioration and immediate care

Standard statement

Older people living with frailty who experience a sudden change in their health can access timely, coordinated and consistent support.

Rationale

Older people with frailty can deteriorate quickly and experience a sudden decline in health following illnesses or stressors. A sudden or unexpected illness can trigger a social care emergency with the need for additional support at home.

Management of a sudden deterioration should be in line with expressed wishes and any future care plan. Real-time access to clinical and care information can enable staff to understand the person's priorities and circumstances. Older people are at higher risk of poor health outcomes when they present at urgent and unscheduled care services. Acute pathways should enable rapid assessment and treatment.[100, 101]

Admission to hospital should be avoided unless it is necessary. Prompt community assessments, including point of care testing, can reduce unnecessary hospital admissions.[100, 102] Virtual wards such as Hospital at Home provide acute care services in a person's home, enabling people to remain independent in familiar surroundings.[6] Urgent assessment and access to social care and/or community-based support may reduce the likelihood of admission to hospital.

When admission to hospital is required, treating people with frailty in a dedicated hospital frailty unit can reduce readmission and shorten the length of hospital stay.[103-105] Older people in frailty units often experience better health outcomes including independence, reduced mortality and fewer complications.[6]

People living with dementia may have vague symptoms or be unable to report their symptoms. This can result in missed diagnoses or higher rates of invasive testing if they experience sudden deterioration in their health. People with dementia are at higher risk of delirium, infection, malnutrition, dehydration, constipation and falls when they are admitted to hospital following deterioriation.[89]

Delirium can be both a cause and a consequence of a sudden deterioration in health. It should be considered in all care settings. People in long-term care or in hospital are at higher risk of delirium.[106] Poorly identified, assessed and managed delirium not only extends length of hospital stay. It can cause significant distress for people, their care partners and staff. [107]

Criteria

10.1 Older people with frailty experiencing a sudden deterioration in health can access, as appropriate:

- an immediate and rapid response from emergency services
- a same day response from an appropriate member of the general practice team
- assessment in their own home or their current place of care
- urgent social care assessment and support
- point of care testing.

10.2 People experiencing a sudden deterioration receive care in a setting in line with expressed wishes and any future care plan.

10.3 NHS boards provide a Hospital at Home or enhanced community support service for older people with frailty which:

- operates for a minimum of 10 hours a day, seven days a week
- has sufficient capacity for their population.

10.4 All hospitals have:

- a dedicated frailty unit or 'front door' frailty team
- an established frailty ward or assessment area with access to a specialist frailty team.

10.5 Older people presenting to hospital are screened for frailty within one hour of admission using a consistent and validated clinical frailty score.

10.6 Older people identify as living with frailty have access to a specialist frailty team within four hours of admission to hospital (or 12 hours if presenting out of hours).

10.7 Older people with frailty receive a CGA within four hours of admission to hospital (or 12 hours if presenting out of hours).

10.8 People receive medicines reconciliation:

- within six hours of admission to an acute care setting
- when they are discharged from hospital or when they move between health or care settings.

10.9 People at risk of delirium receive rapid assessment and management on admission in line with current guidelines.

10.10 Proactive discharge and future care planning begins on admission and continues as a person's health, care, choices, needs or circumstances change.

10.11 Staff are aware of the potential impact of medicines and medicine withdrawals during acute admission.

10.12 People with frailty can access:

- life-saving treatment, including access to high dependency or intensive care at ward level, where clinically appropriate
- specialist palliative care
- rapid supported discharge to die at home or in a homely setting where clinically appropriate.

What does the standard mean for people?
• You can access health care and social care quickly if you become suddenly unwell. • If you become suddenly unwell, you will be assessed and treated in line with your preferences. • You will be involved in decisions about whether to stay at home or be admitted to hospital. • You will receive acute care in the right place for you. • You will receive timely access to acute care services that meet your needs.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • promote a 'home first' approach where appropriate • work collaboratively to support discharge without delay • can access advice and support from senior hospital clinicians when considering whether an older person living with frailty requires hospital admission • have access to a specialist frailty team • screen for frailty using validated tools • act in a timely manner to identify frailty.

What does the standard mean for the organisation?
Organisations: • regularly review and redesign urgent and acute care services • have plans and processes to reduce unnecessary hospital admissions • plan Hospital at Home services with capacity to meet the needs of their population • have an acute frailty unit or dedicated area for the care of older people who are living with frailty.
Examples of what meeting this standard might look like
• Protocols and pathways for a responsive assessment of care needs following a sudden deterioration. • Evidence of a community-based 'urgent care team' who can assess people quickly in their own homes 7 days a week. • Audit of the proportion of requests for Hospital at Home that are accepted. • Evidence of a frailty unit, dedicated frailty beds or a dedicated frailty area within a hospital. • Audit of time taken to identify frailty in older people arriving at a hospital emergency department or acute assessment unit. • Evidence of a dedicated frailty unit which has enough capacity for the population it serves. • Audit of time taken to commence a CGA after frailty has been identified.

Standard 11: Care in hospital

Standard statement

When in hospital, older people living with frailty receive safe, effective and person-centred care.

Rationale

Older people living with frailty make up a large proportion of hospital patients. Staying in hospital often leads to a decrease in physical activity, function and continence.[108] Lights or noise in hospital wards can increase distress and delirium, as can moving between wards.[109] Older people with frailty are at increased risk of healthcare associated infections.[110] When in hospital, older people with frailty should have full, timely access to high dependency units, intensive care units, surgery and other treatments when clinically appropriate. Staff should be aware of and act upon any communication needs, including sight or hearing loss.

Over half of all surgery is performed on people who are over 65 years of age.[111] Older people having surgery are more likely to experience complications compared with younger people.[32] This includes a higher mortality, longer length of stay and increased need for support on discharge.[112]

People who stay in hospital longer than clinically necessary have an increased risk of infections and reduced mobility and independence.[113] Delayed discharges can reduce hospital capacity and reduce the system's ability to respond to increased demand.[114] Older people should have access to services to support them to return home or into a care setting as soon as possible. Effective discharge planning should begin before or at the time of admission and involve a multidisciplinary team.[115]

An immediate discharge letter should provide clear guidance to support recovery. It should include information on follow up and changes to medication.[26] Unpaid carers should be involved in discussions about discharge as detailed in the Carers (Scotland) Act 2016.[26]

There can be delays in recognising and acknowledging dying in hospital. This can lead to investigations and treatments that may be unnecessary or inappropriate. Hospital staff should be skilled at providing palliative care at a generalist level. People should have prompt access to specialist palliative care when required.

Criteria

11.1 Plans for scheduled admission to hospital are:

- discussed with the person and their unpaid carer or care partner
- documented in the person's care plan.

11.2 People scheduled for planned surgery:

- receive a risk assessment before the surgery
- receive multidisciplinary support to maximise their strength and function
- are involved in planning their rehabilitation on discharge.

11.3 People with frailty:

- receive direct admission to the most appropriate area in the first instance
- are not moved between wards or into non-designed patient areas unless there is a clinical need.

11.4 Wards caring for people who may be at risk of frailty:

- have appropriate lighting and noise levels for the time of day
- provide a private space for older people with frailty who are dying
- are designed to promote safe mobility and routine activity
- provide inclusive public information for example large signage
- support visitors where appropriate
- promote healthy sleep.

11.5 Staff in hospitals promote and enable:

- dignity and privacy
- independence
- engagement in physical and social activity
- continence
- skin care
- oral health.

11.6 NHS boards promote rapid discharge to Hospital at Home or enhanced community support where this is the person's choice and is deemed clinically appropriate.

11.7 NHS boards ensure hospital staff have access to specialist palliative care assessment and advice 7 days a week.

11.8 People being discharged to a care home have a future care plan which is shared with unpaid carers or care partners, the care home and the GP practice.

11.9 An immediate discharge letter is produced and available to all relevant staff, including social care staff, within 24 hours of discharge.

11.10 Clinical information about a person's experience in hospital is updated in the person's shared care plan including:

- tests and assessments undertaken and the results
- changes to the person's health or care needs
- changes to medicines
- experience of delirium
- experience of stress and distress.

11.11 Organisations act in the best interests of people who experience delayed discharge.

11.12 The care and support needs of people who are delayed from hospital discharge are reviewed weekly.

What does the standard mean for people in hospital?
• You will be cared for in a clinical environment that meets your needs. • You will be safe and able to maintain your independence. • Planning for discharge will begin as soon as you get to hospital and will be regularly reviewed. • You will be involved in decisions about what will happens when you leave hospital. • If there are changes to plans, you are kept informed and are involved in decisions.
What does the standard mean for staff?
Staff, in line with roles, responsibilities and workplace setting: • recognise and respond to signs of frailty in people in hospital • undertake assessments in line with their roles and responsibilities • ensure ward environments empower people to maintain physical activity and continence, where possible • have sufficient and timely information at point of discharge • work collaboratively to support discharge without delay • share information to enable continuity of care.

What does the standard mean for the organisation?
Organisations: • ensure ward environments meet the specific needs of people with frailty • encourage independence and autonomy • work collaboratively to address the underlying causes that contribute to delayed discharges • develop plans and policies to reduce transfer between wards or care settings • provide access to specialist palliative care assessment and support 7 days a week.
Examples of what meeting this standard might look like
• Data related to number of people in hospital waiting for discharge. • Data related to reasons for delayed discharge. • Data related to admission and readmission rates. • Data related to number of moves within the hospital. • Audit of timeliness and content of immediate discharge letters. • Audit of proportion of people who have an up-to-date future care plan at point of discharge.

Appendix 1: Development of the ageing and frailty standards

Healthcare Improvement Scotland has established a robust process for developing standards, which is informed by international standards development methodology. This ensures the standards:

- are fit for purpose and informed by current evidence and practice
- set out clearly what people who use services can expect to experience
- are an effective quality assurance tool.

The standards have been informed by current evidence, best practice recommendations, national policy and are developed by expert group consensus. The standards have been cocreated with key stakeholders and people with lived experience from across Scotland.

Evidence base

A review of the literature was carried out using an explicit search strategy developed by Healthcare Improvement Scotland's Research and Information Service. Additional searching was done through citation chaining and identified websites, grey literature and stakeholder knowledge. Searches included Scottish Government, PHS, NICE, SIGN, NHS Evidence and Department of Health and Social Care websites. This evidence also informed equalities impact assessments. Standards reference information sources to support statements and criteria. This includes, but is not limited to:

- government policy
- approaches to healthcare delivery and design, such as person-centred care
- clinical guidelines, protocols or standards
- professional or regulatory guidance, best practice or position statements
- evidence from improvement.

Standards development

The development of standards is underpinned by the views and expectations of health care staff, third sector representatives, people accessing the service and the public. The standards development process included:

- scope consultation held in January 2022
- Development Group meetings held between May and November 2023
- an editorial review panel meeting in July 2024
- 13 week consultation on draft standards
- final Development Group meetings in August 2024
- final Editorial Review Panel meeting in October 2024.

The membership of the Standards Development Group and Editorial Review Panel is set out in Appendix 2.

Consultation feedback and finalisation of the standards

Following consultation, the standards development group reconvened to review the comments received on the draft standards and make final decisions and changes. More information can be found in the consultation feedback report, which will be available from Healthcare Improvement Scotland website.

Quality assurance

All Standards Development Group members were responsible for advising on the professional aspects of the standards. Clinical members of the Standards Development Group advised on clinical aspects of the work. The co-Chairs had lead responsibility for formal clinical assurance and sign off on the technical and professional validity and acceptability of any reports or recommendations from the group.

All Standards Development Group members made a declaration of interest at the beginning of the project. They also reviewed and agreed to the Standards Development Group's Terms of Reference. More details are available on request from his.standardsandindicators@nhs.scot.

The standards were developed within the Operating Framework for Healthcare Improvement Scotland and the Scottish Government (2022), which highlights the principles of independence, openness, transparency and accountability.

For more information about HIS's role, direction and priorities, please visit: www.healthcareimprovementscotland.org/

Appendix 2: Membership of the Standards Development Group

Name	Position	Organisation
Paul Baughan	**(Co-Chair)** GP/Professional Advisor for Ageing and Health	NHS Forth Valley/Chief Medical Officer Directorate, Scottish Government
Phyo Kyaw Myint	**(Co-Chair)** Professor of Medicine of Old Age and Honorary Consultant Geriatrician	University of Aberdeen/NHS Grampian
James Battye	Senior Improvement Advisor	Healthcare Improvement Scotland
Leanne Black	Lead Clinical Pharmacist Frailty	NHS Greater Glasgow and Clyde
Anne Blackburn	Retired district nurse/ midwife	Scottish Older People's Assembly (SOPA)
Kirsty Boyd	National Clinical Lead for Palliative Care	Scottish Government
Janice Cameron	Joint National Lead	Scottish Care
Mark Delicata	Consultant Physician– Medicine for the Elderly	NHS Fife
Joanna Earle	Inspector	Healthcare Improvement Scotland
Ros Fraser	Speech and Language Therapist	NHS Lothian
Scott Hamilton	Improvement Advisor	Healthcare Improvement Scotland
Mhairi Hastings	Associate Director of Nursing	Healthcare Improvement Scotland
Chris Hay	Geriatric Registrar	NHS Greater Glasgow and Clyde

Name	Position	Organisation
Mark Hazelwood	Chief Executive	Scottish Partnership for Palliative Care
Vicky Hough	Senior Clinical Pharmacist	NHS Forth Valley
Lynsey Kemlo	Senior Improvement Adviser	Care Inspectorate
Laura Kerr	Adults Policy and Practice Lead	Social Work Scotland
Kyrsta Macdonald-Scott	Advanced Practice Physiotherapist	NHS Lothian
Phil Mackie	Consultant in Public Health	NHS Grampian
Nicola McArdle	Senior Improvement Adviser	Care Inspectorate
Lucy McCracken	Consultant Geriatrician	NHS Greater Glasgow and Clyde
Louise McKay	Nurse Consultant, Older Adults	NHS Forth Valley
Hazel Miller	Consultant Geriatrician	NHS Greater Glasgow and Clyde
Jane Mimnaugh	Alzheimer Scotland Nurse Consultant	NHS Lanarkshire
Lara Mitchell	Consultant Medicine for the Elderly National Clinical Lead Frailty	NHS Greater Glasgow and Clyde
Susan Moug	Consultant General and Colorectal Surgeon	NHS Greater Glasgow and Clyde
Connie Murray	Improvement Advisor	Healthcare Improvement Scotland
Shona Omand-Smith	Commissioning Lead	Aberdeen City Health and Social Care Partnership
David Paterson	Chair	Scottish Older People's Assembly (SOPA)
Sarah Pickstock	Lead Clinician Specialist Palliative Care	NHS Dumfries and Galloway

Name	Position	Organisation
Joy Reid	Nurse Consultant Older People and Frailty	NHS Fife
Dawn Skelton	Professor of Ageing and Health, Ageing Well Research Group, Research Centre for Health (ReaCH)	Glasgow Caledonian University
Rowan Wallace	Consultant Older People's Medicine/Chair British Geriatrics Society Scotland	NHS Ayrshire and Arran
Eilaine White	Clinical Academic Nurse Consultant for Older People	NHS Tayside/University of Dundee

The Standards Development Group was supported by the following members of the standards and indicators team at Healthcare Improvement Scotland:

- Rachel Hewit, Programme Manager
- Silas McGilvary, Project Officer
- Stephanie Kennedy, Administrative Officer
- Fiona Wardell, Team Lead

Appendix 3: Membership of the Standards Steering Group

Name	Position	Organisation
Paul Baughan	**(Co-Chair)** GP/Professional Advisor for Ageing and Health	NHS Forth Valley/CMO Directorate, Scottish Government
Phyo Kyaw Myint	**(Co-Chair)** Professor of Medicine of Old Age and Honorary Consultant Geriatrician	University of Aberdeen/NHS Grampian
Harriette Campbell	Vice-chair	Scottish Older People's Assembly (SOPA)
Jacqueline Dennis	Senior Improvement Adviser	Care Inspectorate
Mark Evans	National Spiritual Care Strategic Advisor Operational Lead	Scottish Government
Jennifer MacDonald	Inspector	Healthcare Improvement Scotland
Lucy McCracken	Consultant Geriatrician	NHS Greater Glasgow and Clyde
Marie McKerry	Chief Nurse	Care Inspectorate
Winifred McLure	Senior Inspector	Healthcare Improvement Scotland
Lara Mitchell	Consultant Medicine for the Elderly National Clinical Lead Frailty	NHS Greater Glasgow and Clyde, Healthcare Improvement Scotland
David Paterson	Chair	Scottish Older People's Assembly (SOPA)

Name	Position	Organisation
Marie Paterson	Chief Inspector for Adult Services	Care Inspectorate
Belinda Robertson	Associate Director of Improvement	Healthcare Improvement Scotland
Fiona Wardell	Standards and Indicators Lead	Healthcare Improvement Scotland

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