QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Training and development

Chapter 6 Training and development of staff

Context

High quality management of frail older people is challenging because they often present non-specifically (for example with falls, immobility, delirium) which can make the immediate diagnosis obscure.

Training of all health care professional and providers has not traditionally focused on the needs of older people, thus there is a lack of confidence and expertise in managing older people and conditions associated with ageing. Junior doctors are usually the 'first receivers' at the front door (emergency department or acute medical unit), and few will have any substantial training in geriatric medicine and the formulation of the non-specific presentation. This may be in part due to the possible decline in the teaching of geriatric medicine in UK medical schools[1 2].

Aside from the knowledge of frailty syndromes, there is a skill involved in geriatric medicine – history taking is challenging, for example because of sensory impairment, dementia or delirium. Often a collateral history is needed which may not be readily accessible in the emergency setting and time pressures, not least the four hour emergency care standard, may place pressure on staff not to focus on anything other than immediate triage – thereby undermining the EDs ability to undertaken immediate clinical evaluation and management t address the individual's needs.

A positive attitude to managing frail older people is a pre-requisite for implementing the appropriate knowledge and skills; health care professionals' attitudes towards frail older people could be better, and ageism remains a problem in the health system[3-5].

It follows that because the nature of the assessment and care for older people is multi-disciplinary, the principles of joint training for all professionals should be considered where appropriate.

Skills and competencies

Generic

- Communication skills, often under challenging conditions e.g. to take a detailed history from the person, ability to explain things in more than one way, give encouragement
- Listening skills
- Compassion, empathy and respect
- Clinical reasoning and assessment skills
- Time/patience and the ability to build a rapport/relationship quickly
- Awareness of community services
- Risk assessment/management skills surrounding discharge planning
- Multidisciplinary team working skills
- Personal care training skills
- Moving and handling skills
- Basic life support skills
- Ability to balance contrasting needs of a complex individual

Additional training and development of staff in managing frail older people

Comprehensive training of staff managing care of older people in the emergency settings is paramount to safe and effective delivery of care. This should not be restricted to medical staff, but all health care agencies, social services and community teams involved in older peoples' care. Where ever possible and appropriate, this training should be undertaken jointly.

British Geriatrics society best practice guide 2008[6] elaborates on the care of the older person in the ED. It focuses on person-centered care and equity of access to full range of investigations and treatment. Particular emphasis is placed on information giving to older people and carers, effective management plans, consideration of advance care planning, dignity, end of life care, cognitive assessments and palliative care. Where older people need to be admitted, local providers should ensure prompt assessment, management plan and fast tracking of older people with fracture neck of femur, stroke and multidisciplinary assessment and care planning including discharge planning and intermediate care facilities. Specialist areas will also include assessment for falls, rapid assessment geriatric clinic, day hospital, and TIA (transient ischaemic attack) clinics as part of comprehensive geriatric assessment and may include a combination of medical, nursing, physiotherapists, occupational therapists, social worker, specialist nursing and therapy staff. The multidisciplinary team should also be aware of Department of Health guidance on care pathways for older people with complex health needs[7].

Medical staff

Doctors in training follow a defined curriculum dependent on their grade and specialism, with defined learning objectives as outlined in their learning portfolio, knowledge skills and work based assessments through a competency based curriculum approved by the General Medical Council and the guidance provided in the Gold Guide. Senior staff should regularly update their skills in aspects of care of older people[6]. Training of nurses, doctors and allied health professionalsshould include skills, knowledge and attitudes in relation to:

- Assessments, particularly mental state, cognitive assessments and functional ability
- Updated clinical practice guidelines
- Local operational policies on assessment and management of the older person

Background in Emergency Medicine

- Post-registration modules for emergency care doctors, nurses and allied health professionals should include sessions on the needs of the older person accessing emergency care which includes the aging process, dementia, delirium, falls and frailty
- Emergency Nurse Practitioner/Advanced Nurse Practitioner/Advanced Clinical Practitioner/Physician Assistant/Consultant Allied Health Professional awards should also include the content outlined above; this is especially important as they may be the only clinician to assess, plan and implement care for the older person
- Clinical advocates for the older person in emergency care should provide clinical updates to ED staff as and when necessary, e.g. following the publication of relevant guidelines.
- There should be an emergency care network of such clinical advocates in order to share information and develop new initiatives
- Universities and Emergency Departments should consider asking older service users to provide input to any education and training provided

Background in geriatric medicine

Geriatricians should be well trained in the clinical assessment and management of frail older people, but may be unfamiliar with the specific challenges of working within an emergency department.

Areas that may need additional training include:

- System based risk assessment
- Handover and communication in a full-shift system
- Structured assessment of older people with trauma including hip fractures, head injury and poly trauma

Background in Acute Medicine

For trainees in Acute Medicine the curriculum recommends that in the ST4 or ST5 year there should be at least four months experience of acute geriatric care. Within the specialist skill section of the acute internal medicine curriculum is the opportunity for acute medicine trainees to gain extra competencies in more specialised areas. Trainees have to achieve competences that are prescribed by the relevant supervising authorities and among these specialties, and directly relevant to care of frail older people, are stroke medicine and palliative care.

Useful references

Curriculum for Urgent care Common Stem trainees
http://www.accsuk.org.uk/curriculumfolder/curriculum.html
Curriculum for Core Medical Training
http://www.gmc-uk.org/GIM_level_1___May_07.pdf_30346050.pdf
Acute medical task force report
http://bookshop.rcplondon.ac.uk/contents/pub235-b42eb97d-209b-4ecd-9127-ef95cc21c819.pdf

Nursing

The recent Health Service Ombudsman's[8] report tells the stories of ten people over the age of 65, from all walks of life and from across England. Friends and families described them variously as loving partners, parents and grandparents. Many of them were people with energy and vitality, active in their retirement and well known and liked within their communities. They had in common experiences of suffering unnecessary pain, indignity and distress while in the care of the NHS. Poor care or badly managed medication contributed to their deteriorating health, as they were transformed from alert and able individuals to people who were dehydrated, malnourished or unable to communicate. As one relative reported: 'Our dad was not treated as a capable man in ill-health, but as someone whom staff could not have cared less whether he lived or died'.

People attending the emergency department come with a multitude of nursing care needs ranging from minor injuries and illness through to life threatening conditions. In addition to physical needs, the person has psychological, social and emotional needs that can often require highly skilled nursing interventions. Often, relatives and friends of older people may also have needs whilst attending Urgent Care Services. Nurses provide continuity to all aspects of care; it is essential that the quality of nursing care should be of the highest standards.

The Essence of Care[9] benchmarks launched by the Department of Health in 2010 include bladder, bowel & continence care, nutrition, prevention and management of pain, personal hygiene, pressure ulcer prevention and care, respect and dignity, safety and communication. The Royal College of Nursing recently launched the Principles of Nursing Practice (2010). Developed in partnership with patient and user organisations; the Department of Health (DH) and The Nursing and Midwifery Council (NMC), they describe what people and service users can expect from nursing services (in any setting) and from those providing their nursing care - be it from a Registrant, Health Care Assistant, or a Nursing Student.

The Principles underpin practice with peoples' expectations and rights to be autonomous, treated equally and fairly and treated with dignity and respect. To put it simply, the Principles of Nursing Practice describe what everyone can expect from nursing.

Appendix 1 provides a summary of the Essence of Care benchmarks which should be used in conjunction with the Principles of Nursing Practice when planning and implementing nursing care for Older Persons in Acute Hospital settings.

Useful references

http://www.rcn.org.uk/development/practice/principles/the_principles

Physiotherapy

Within the acute geriatric setting, physiotherapists should have all the general skills expected in terms of communication and clinical reasoning together with an understanding of the hospital organisation and community services available. Therapists would be expected to have advanced skills in risk assessment and assessment of mental capacity and common presentations in older people such as falls, delirium, dementia, malnutrition, fragility fractures etc. Due to the nature of the acute assessment, including home visits, physiotherapists will often be working alone and as such they will need to be competent and confident in making safe and effective decisions with the individual. Knowledge of the complexity of health and social needs and an ability to constructively liaise with other professions and agencies to meet the needs of the individual is essential. Physiotherapists often work alongside occupational therapists, and other health care professionals, triaging older people in an urgent care situation or at the emergency department.

Therapists need to demonstrate their own professional development and may be asked to present this to the Health Professions Council if requested. Advanced courses are available to physiotherapists choosing to specialise in geriatrics and acute healthcare.

Useful references

CSP (2010) Developing a CSP vision for the future of Physiotherapy: draft materials. Available at:

http://www.csp.org.uk/uploads/documents/csp_vision -2010.pdf

Scottish qualifications website with specific information on falls and fractures not specifically therapy related

http://www.sqa.org.uk/sqa/46010.html

PGCert in falls and osteoporosis management

http://www.derby.ac.uk/osteoporosis-and-falls-management-pg-cert

Masters in Gerontology

http://www.educaedu.co.uk/msc-gerontological-practice-masters-19433.html

Occupational therapy

Undergraduate occupational therapy training gives a sound basis for working with frail older people. Many older people attend emergency departments with medical problems which affect their ability to carry out their usual activities of daily living, such as using the toilet or getting in and out of bed[10-12]. In some cases this results in older people staying in hospital for longer than their medical condition alone would require. This can be detrimental to older peoples' recovery by increasing their dependence and delaying their transfer back to the community but also results in additional health care costs whilst they receive rehabilitation or arrangements for support at home.

Recognising the complex needs of older adults attending ED many hospitals now employ occupational therapists to work in the ED. Occupational therapists are able to provide assessment for functional and social needs and provide the equipment and support required, thus preventing unnecessary admissions for older people.

The added expertise and involvement of occupational therapists in reablement teams contribute to successful reablement services as they have extensive knowledge and understanding of the equipment and adaptations that are a major part of reablement

services[13]). Occupational therapists are well placed to provide enhanced training to home care staff to deliver efficient and effective reablement services[14].

Useful references

College of Occupational Therapists http://www.cot.co.uk/.

College of Occupational Therapists Specialist Section - Older People http://www.cot.co.uk/cotss-older-people/cot-ss-older-people

Masters in gerontology http://www.educaedu.co.uk/masters/gerontology

Reablement evidence: http://www.scie.org.uk/publications/ataglance/ataglance46.asp

Pre-Hospital Care

Historically Ambulance Services have used the Institute of Healthcare Development's (IHCD) vocational educational programme to develop and educate their staff using a skills escalator approach[15]. Recently ambulance services have moved to the Higher Education (HE) route following the publication of programme and curriculum recommendations by the Joint Royal Colleges Service Liaison Committee (JRCALC)[16], the requirements of the Health Professions Council UK[17] and the involvement of the College of Paramedics[18].

The curriculum for the paramedic education programme does not have a specific module on geriatric medicine. However, the competencies needed for assessing and managing frail older people, which covers the psychosocial context and working within a wider healthcare team, are addressed in different modules. There is also a focus on the attitudinal aspects of care, communication barriers and techniques, assessment of capacity, as well as training in ethics and law, with reference to advance decisions and advance care planning.

There is scope for delivering a more specialist programme in geriatric medicine for ambulance clinicians, which would both consolidate the knowledge, skills and attitudes needed to deliver best practice in this population group, as well as highlight the importance of this specialty in an ageing population, where frail older people represent a large proportion of acute admissions to hospital.

Appendices

Appendix 1 Essence of Care benchmarks

Number	Standard	Key Outcome	Domain	Description	Relevant Tools
1	**Bladder, Bowel & Continence Care**	People's bladder and bowel care needs are met.	**Screening and assessment** **Planning, implementation, evaluation and revision of care** **Environment**	Older people receive bladder and bowel continence screening and assessment on initial contact Care is planned, implemented, continuously evaluated and revised to meet individual bladder and bowel care and preferences. All bladder and bowel care is given in an environment appropriate to *patient's* needs and preferences	
2	**Food and Drink**	People are enabled to consume food and drink (orally) which meets their needs and preferences.	**Screening and assessment** **Planning, implementation, evaluation and revision of care** **Availability** **Presentation**	*Older people* are screened on initial contact and those identified at risk receive a full nutritional assessment Care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink. *Older people* can access food and drink at a time according to their needs and preferences *F*ood and drink is presented in a way that is appealing to them *Older people* receive the care and assistance they require with eating and drinking *F*ood and drink intake is monitored and recorded	British Association for Parenteral and Enteral Nutrition "MUST" Screening Tool. http://www.bapen.org.uk/pdfs/must/must_full.pdf

			Assistance **Monitoring**		
3	**Prevention and Management of Pain**	People experience individualised, timely and supportive care that anticipates, recognises and manages pain and optimises function and quality of life.	**Assessment** **Care planning, intervention, evaluation, review and prevention**	Older people have an initial assessment within 15 minutes of arrival and ongoing, comprehensive assessment of their pain. *Older people* individualised care concerning pain that is planned, implemented, continuously evaluated and revised in partnership with *people*, staff and carers	Royal College of Physicians, British Geriatrics Society and British Pain Society. *The assessment of pain in older people: national guidelines*. Concise guidance to good practice series, No 8. London: RCP, 2007 Appendices 2/3/4
4	**Personal Hygiene**	People's personal hygiene needs and preferences are met according to their individual and clinical needs.	**Assessment** **Assistance**	Older people are assessed to identify the advice and/or care required to maintain and promote their personal hygiene. Older people receive the care and assistance they require to meet personal hygiene needs and preferences.	
5	**Prevention and Management**	People experience care that maintains or	**Screening and assessment**	Older people are screened on initial contact and those identified at risk of developing pressure ulcers receive a full assessment of their risk.	RCN Pressure Ulcer Risk Assessment

	of Pressure Ulcers	improves the condition of their skin and underlying tissues.	**Planning, implementation, evaluation and revision of care** **Prevention – repositioning** **Prevention – pressure redistribution**	Care is planned, implemented, continuously evaluated and revised to meet their individual needs and preferences concerning pressure ulcer prevention and management *Older people* are repositioned to reduce the risk, and manage the care, of pressure ulcers *Older people* are cared for on pressure redistributing support surfaces to reduce the risk, and manage the care, of pressure ulcers	and Prevention. Royal College of Nursing 2003. National Institute for Health and Clinical Excellence. Quick reference guide Sept 2005
6	**Respect and Dignity**	People experience care that is focused upon respect and dignity.	**Attitudes and behaviours Personal boundaries and space** **Communication** **Privacy – confidentiality**	*Older people* and carers feel that they matter all of the time *Older people* personal space is protected by staff *Older people* and carers experience effective communication with staff, which respects their individuality *Older people* experience care that maintains their confidentiality *Older people* care ensures their privacy and dignity,	

			Privacy - dignity and modesty	and protects their modesty	
7	**Safety**	People, their carer, visitors and staff feel safe, secure and supported.	**Observation and Privacy** **Planning, implementation, evaluation and revision of care**	*Older people* experience care in an environment that allows safe observation and privacy *Older people* care is planned, implemented, continuously evaluated and revised to meet their safety needs and preferences	
8	**Communication**	People and their carers experience effective communication.	**Interpersonal skills** **Assessment of communication needs** **Information sharing** **Identification and assessment**	All staff demonstrate effective interpersonal skills All communication needs are assessed on initial contact and are regularly reassessed. Additional communication support is negotiated and provided when a need is identified or requested Information that is accessible, acceptable, accurate and meets needs is shared actively and consistently with all *people* and carers and widely promoted across all communities When appropriate, the principal carer is identified and an assessment is made with them of their needs, involvement, willingness and ability to collaborate with staff in order to provide care All staff communicates fully and effectively with each other to ensure that older people and carers benefit	

			of principal carer **Co-ordination of care** **Empowerment to communicate needs**	from a comprehensive and agreed plan of care which is regularly updated and evaluated. *Older people* and carers are enabled to communicate their individual needs and preferences at all times	

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