

Review of
Older People's Services
in
NHS Ayrshire and Arran

Appendices

December 2002

NHS Quality Improvement Scotland is built on the expertise developed within the Clinical Standards Board for Scotland, the Clinical Resource and Audit Group, the Health Technology Board for Scotland, the Nursing and Midwifery Practice Development Unit and the Scottish Health Advisory Service. The purpose of NHS Quality Improvement Scotland is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

This report covers a review of older people's service in NHS Ayrshire and Arran, which was undertaken by the Scottish Health Advisory Service prior to its integration into NHS Quality Improvement Scotland on 1 January 2003. Copies of the Quality Indicators for Older People's Services [first published by the Scottish Health Advisory Service (SHAS)] are available from NHS Quality Improvement Scotland.

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OLDER PEOPLE ASSESSMENT FRAMEWORK

Quality Indicator 1		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
General Policies							
PRINCIPLE: Written policies are in place for key aspects of the service.							
1.1	Written policies are in place for key aspects of service provision that are reviewed and updated. The implementation is audited annually, issues identified and appropriate action taken.						
1.1.1	There is a policy for access to advice, referral, assessment and admission to specialist services including rehabilitation.		X				
1.1.2	There is a multidisciplinary/multi-agency policy, including GPs and social work staff, for discharge from hospital based services.			X			
1.1.3	There is a multi-agency policy for elder abuse.			X			
1.1.4	There is a multi-agency policy for eligibility and allocation for continuing care provision by NHS and an appeal system.			X			
1.1.5	There is a multi-agency policy for eligibility and allocation for NHS and social respite.			X			
1.1.6	There are clear policies in all clinical areas including: <ul style="list-style-type: none"> • cardio-pulmonary resuscitation; • verification of expected death; • terminal care; • simple medicines; • tissue viability; • continence; • infection control; • food and health nutrition; and • extended role of the nurse. 		X	X X X X X X X			
<p>Commentary</p> <p>1.1.1 We did not find evidence of a policy.</p> <p>1.1.6 Arran View Nursing Home has no resuscitation policy and consultant geriatrician has decided not to follow the Primary Care Trust policy.</p> <p>Food and nutrition is well developed but we did not find an overarching policy in either Trust except a draft one in each Trust.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Guidelines are in place to ensure older people's rights are observed.							
1.2	Guidelines are in place to ensure older people know and understand their rights and that their rights are observed.						
1.2.1	There are clear arrangements or management of patient funds, including dealing with the funds of patients incapable of dealing with their own affairs.			X			
1.2.2	Staff have received appropriate training in relation to older people's rights.		X				
1.2.3	Relevant clinical information is made available to patients to enable informed discussion and choice and it meets the needs of patients with a sensory impairment.			X			
1.2.4	There is clear guidance on respect of confidentiality and when, and if, information can be shared with family members or others.			X			
1.2.5	Patients are not transferred without notifying relatives/carers.			X			
1.2.6	There is a clear complaints procedure.			X			
1.2.7	There is a clear appreciation of the rights of the older person.			X			
Commentary 1.2.1 No guidance on confidentiality of nursing notes outside bedrooms in Crosshouse Hospital. 1.2.2 No training in elder abuse, Incapacity Act and advocacy. Only staff studying degree modules do.							
PRINCIPLE: All patients should have access to an independent advocate.							
1.3	There is a NHS Board/multi-agency specification for advocacy services which addresses good practice guidelines.						
1.3.1	NHS Board/Joint Community Care Plans identify the need for advocacy services which are translated to a service specification.		X				
1.3.2	There is an allocated budget.		X				
1.3.3	There is evidence that the NHS Board is implementing the Advocacy Good Practice Guidance.		X				
1.3.4	There is an identified named person responsible for the co-ordination of advocacy services.			X			
1.3.5	There is an ongoing training programme for staff and advocates in use. Clear responsibility is allocated for advocacy training.	X					
Commentary Plans have been developed but there are no formal services for hospital patients. There is only community advocacy services are in East and South Ayrshire Councils. 1.3.5 As there is no advocacy service then this can not be achieved.							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
1.4	Advocacy services are supported by the Trust in a positive way.						
1.4.1	There is evidence of mechanisms in place to enable issues of concern to be raised with managers/staff.	X					
1.4.2	There is a referral protocol available setting out how the service may be accessed by patients.	X					
1.4.3	Patients have a choice of advocate.	X					
1.4.4	There are people with identified advocates whose needs are being met.		X				
1.4.5	A range of communication methods have been employed indicating eligibility criteria and referral procedures, e.g. leaflets, posters, and direct communication to user groups in order to ensure maximum awareness.	X					
1.4.6	There are examples of information adjusted to the comprehensive needs of targeted individuals or groups.	X					
<p>Commentary</p> <p>1.4 As there is no service this can not be achieved. The policy is only in draft and the plans not implemented.</p> <p>1.4.4 Some services have previously used the Princess Trust but no patients were identified during the visit.</p>							

Quality Indicator 2 Management of Services		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: There is effective interdisciplinary liaison.							
2.1	Arrangements are in place for effective liaison between disciplines, departments and different levels of care.						
2.1.1	There is effective, clinical and organisational liaison between Geriatrics, Psychiatry, Orthopaedics, A and E, General Medicine and Surgery and the primary health care team. There is efficient access to the geriatricians and their teams.		X				
2.1.2	There is evidence of good communication within and between all levels of staff.			X			
2.1.3	There is close working relationship between primary and secondary care.			X			
2.1.4	There is a close working relationship and communication with social workers.				X		
<p>Commentary</p> <p>2.1.1 Fairly good in the South but poor in the North.</p> <p>2.1.3 Good everywhere except at consultant level. There is a wide variation in the number of home visits undertaken by consultants.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: There is effective prescribing.							
2.2 Medications are used appropriately and their use reflects best practice and values.							
2.2.1	There is appropriate prescribing, dispensing, administration and compliance that complies with an agreed policy and guidelines.		*	X			
2.2.2	There is a drug formulary that is particularly sensitive to the needs of older people.		*	X			
2.2.3	Older people have equitable access to evidenced-based new treatments.				X		
2.2.4	There is evidence of a timely supply of appropriate drugs to the departments and to patients on discharge.			X			
2.2.5	Pharmacy services and advice are accessible at ward/patient level to promote compliance.		*		X		
2.2.6	Drug dispensing, prescribing and administration errors are reported and reviewed.				X		
2.2.7	There are appropriate mechanisms to ensure best prescribing practice.		*	X			
2.2.8	There should be evidence of a wound management formulary and availability of specialist tissue viability advice.				X		
2.2.9	Use of tranquilisers and sedation should be reviewed and limited.				X		
2.2.10	Facilities for in-patient self medication and the supply of dosette boxes are available.		*	X			
2.2.11	Any drug trials comply with a clear policy from the ethics and research committee.			X			
<p>Commentary</p> <p>2.2.1 *There is over prescription of 'as required' drugs and these are often without qualification and number of doses in 24 hours.</p> <p>2.2.2 Not in the Primary Care Trust.</p> <p>2.2.5/7 *There is no regular pharmacy advice in the community hospitals except at Arran View Nursing Home and Holmhead Hospital.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Emergency and non-emergency transport services meet the needs of the users.							
2.3	There is a written service agreement for emergency and non-emergency transport services for older people.						
2.3.1	Transport arrangements should be appropriate to the needs of patients as well as the different parts of the service, i.e. in patient, outpatient and day hospital.			X			
2.3.2	Transport services have emergency contacts for users.			X			
2.3.3	Written information is available for older people about transport.			X			
2.3.4	All vehicles are equipped to care for older people including people in wheelchairs, patient mobility equipment and the vehicles meet the required safety standards.			X			
2.3.5	Transport staff should received manual handling training.			X			
<p>Commentary</p> <p>There appear to be no concerns about transport in Ayrshire and Arran apart from some of the rural and island communities.</p> <p>There appears to be good liaison with the Scottish Ambulance service and managers.</p>							
PRINCIPLE: Patients have a choice of nutritious food.							
2.4	There should be a high standard of food and adequate nutrition for patients, staff and visitors.						
2.4.1	Staffing levels and skill-mix allow individual nutritional requirements to be met including assistance to ensure that users can enjoy their meals and receive the nutrition they need.			X			
2.4.2	Menus cater for special dietary, nutritional and cultural needs.				X		
2.4.3	There is a fresh supply of water that is accessible at all times to patients.				X		
2.4.4	The care environment and special eating utensils meet the needs of individual patients.		*	X			
2.4.5	Oral hygiene needs of patients are met including denture and dentist assessments.			X			
2.4.6	Each patient has an individual nutritional assessment and dietary support with special provision as appropriate.				X		
2.4.7	There is flexible availability of meals compatible with choice.				X		
2.4.8	There is adequate provision and facilities for staff.			X			
<p>Commentary</p> <p>2.4.4 *Dining rooms are not used in the Acute Hospitals. Some meals are served with all three courses on the tray.</p> <p>We were very impressed with the work that has been undertaken across Ayrshire with regard to nutrition.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Patients are in a safe environment that supports self-determination and well being.							
2.5 There is a health and safety policy.							
2.5.1	Health and safety audits are undertaken on a regular basis.		*	X			
2.5.2	There is a programme to manage the physical internal and external environment to reduce and control hazards and risks and ensure personal safety.			X			
2.5.3	Patient and staff security is maintained.			X			
2.5.4	There is a policy for the management of aggression.			X			
2.5.5	Audit results are collated and influence preventative policies.		*	X			
2.5.6	There is a furniture and equipment replacement programme in place.		X				
2.5.7	Corridors and public rooms or facilities are free from obstacles; patients are able to move around the ward safely with minimal risk of harm to themselves and/or others.		X				
2.5.8	There is appropriate access for the disabled and wheelchair users.			X			
2.5.9	Directions to all wards, departments and clinics are clear and easily understood.			X			
2.5.10	Accommodation is fit for purpose, meets the social and therapeutic needs of the patients and is regularly maintained.		X				
2.5.11	Mixed sex accommodation standards are adhered to.		X				
2.5.12	Patients' hygiene is maintained.			X			
2.5.13	The Trust has processes in place for assuring quality within non-clinical service areas.				X		
<p>Commentary</p> <p>2.5.1/5 *Audits were not up to date in some of the acute wards visited and we saw little evidence of preventive action plans at local level.</p> <p>2.5.7 Some wards are very cluttered. The storage of spare equipment is an issue.</p> <p>2.5.10 Not all accommodation is fit for purpose.</p> <p>2.5.11 In some of the community hospitals mixed sex standards are not being achieved.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Service users are actively involved in the planning of services.							
2.6	The NHS Board should identify the involvement of users in the development of the Health Improvement Plan (HIP) and the Joint Community Care Strategy.						
2.6.1	The plan should identify how service users will be actively involved in all stages of the planning process.			X			
2.6.2	There will be a strategy and review team with user representation.			X			
2.6.3	There is a process in place to ensure accessibility of information.			X			
Commentary							
2.7	Users and carers are actively involved in the planning, review and development of services.						
2.7.1	The service has an up-to-date documented policy for actively involving users/carers.				X		
2.7.2	The policy identifies how ongoing involvement between patients/carers and provider is to be achieved.				X		
2.7.3	Patient satisfaction surveys are undertaken.				X		
2.7.4	There is evidence of a Patients' Council or like and patient groups in continuing care wards.	*			X		
Commentary 2.7.4 *We found no patient groups in the continuing care wards. We were impressed with the many examples of good practice.							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: There are agreed arrangements for joint working.							
2.8	There is a jointly agreed multi-agency strategy that includes an implementation plan, timescales and priorities for development with shared values and principles on the shape and scale of services.						
2.8.1	A joint strategy signed up to by all stakeholders, including service users and carers, is in use and fully implemented.		X				
2.8.2	There is a joint planning structure with financial frameworks in use.			X			
2.8.3	There is an agreed approach to population needs assessment and assessment tools incorporating other agency assessments.			X			
2.8.4	There is a system to ensure that agencies share information.		X				
2.8.5	There are joint agreements and protocols with agreed timescales and priorities in use for: <ul style="list-style-type: none"> • assessment • admission • referral • discharge planning • risk assessment • critical incidents • emergency/crisis management • joint funding and resources 		X X X X		X X X		
Commentary 2.8.1 The strategy is in draft and out for consultation.							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: The staffing levels and skill-mix of all disciplines including medical, nursing and AHPs are adequate to meet the health and social needs of patients.							
2.9	Medical, AHPs and nursing staffing levels and skill-mix adequately and consistently meet the needs of the patients and the environment, e.g. acute assessment, rehabilitation, continuing care and day hospital.						
2.9.1	Managers measure case mix and caseload, both systematically and regularly and requirements are reflected in service development plans.			X			
2.9.2	There is evidence from staff, patients and relatives that the staffing levels are perceived to be adequate.		X				
2.9.3	Junior medical staffing and working hours meet the legal requirements.			X			
2.9.4	There is adequate IT and clerical support for the administration and management responsibilities of charge nurses and other clinical staff, including secretarial support, bed management and the use of bank and agency nurses.		X				
2.9.5	If a charge nurse is responsible for hospital bed management, this should be reflected in staffing levels on the ward.		X				
2.9.6	There is a range of support for nutrition, stroke, sensory deprivation, infection control, tissue viability, continence and for discharge arrangements.			X			
2.9.7	The domestic, clerical and other support staff is adequate to support the ward/department team to undertake non-clinical duties.			X	*		
<p>Commentary</p> <p>2.9.2 Users and carers stated they felt there wasn't adequate staffing and these views were confirmed in surveys.</p> <p>2.9.7 *In the Primary Care Trust domestics now undertake bed making duties and this has helped nurses.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Patients have a named nurse who is responsible for their care.							
2.10	There should be a named nurse/primary nurse system that clearly identifies the nurse responsible for each patient.						
2.10.1	Various measures are used to assist patient and relative awareness of names of staff responsible.			X			
2.10.2	Staff have adequate knowledge of the patient's health and social needs to make informed decisions.				X		
2.10.3	Shift patterns and other hours of working are based on the needs of older people and not the convenience of staff.			X			
2.10.4	Shifts are designed to be workable, allowing for breaks and quality reporting time between teams.			X			
2.10.5	Levels of vacancy and sick leave are monitored and appropriate action taken.			X			
<p>Commentary</p> <p>2.10.3 We are concerned about the implementation of a 12 hour shift system as a result of the EU working time directive. This is being implemented in some areas with little thought to the needs of patients and evaluation.</p>							

Quality Indicator 3		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
Service Delivery							
PRINCIPLE: Patients have a needs assessment.							
3.1 A comprehensive needs assessment is carried out within primary care.							
3.1.1	People over 75 years are offered an annual health and social needs assessment at their GP's surgery or at home. Referral is made to specialist services as appropriate.			X			
3.1.2	Each person seeking a consultation who is over the age of 65 in primary care services receives a full health and social assessment when appropriate.						X
3.1.3	Assessments in primary care should take into account the patient's current situation and their desired level of functioning, including opportunities for rehabilitation.			X			
Commentary							
3.2 All older people admitted to hospital are assessed on arrival for their clinical and social care needs.							
3.2.1	Where appropriate, a prompt initial assessment system is in place, led by a senior member of medical staff, which includes a review of clinical and social care needs.			X			
3.2.2	The purpose of each assessment is made clear both to patients and relatives where appropriate.			X			
3.2.3	Initial assessments lead to care plans that identify every aspect of patient care with agreed goals and review dates, which act as a guide for the depth/scope/urgency for further assessment.			X			
3.2.4	Patient ward moves are minimised.		X				
Commentary 3.2.4 There are far too many patient moves.							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
3.3	Each patient receiving community or inpatient health services has a confidential care plan agreed between patient, staff teams and carer with a review.						
3.3.1	Each profession involved in care delivery must provide a written contribution to a patient's overall care plan, dated and signed. This care plan should be available to other professions but respect a patient's confidentiality.			X			
3.3.2	Each patient is fully informed and agrees, where possible, to the care plan.		*	X			
3.3.3	There should be evidence of a multidisciplinary integrated care planning method.		X				
3.3.4	The overall care plan outlines the aims and objectives of care for the individual, agreed goals and what actions and interventions have been arranged in order to achieve them.			X			
3.3.5	There is evidence in the care plan of the named nurse and other professions, patient/carers agreement and their involvement in the delivery of care.			X			
3.3.6	The care plan states how reviews, evaluation and reassessments will be made, by whom, when, how and where.			X			
3.3.7	The care plan is provided for as long as the individual's conditions and circumstances necessitate and it reflects individual needs.			X			
3.3.8	When necessary complex care packages enable older people to be cared for in their homes, with the aim of maintaining their independence and preventing admission or readmission to hospital.			X			
3.3.9	Carers' needs are assessed and arrangements are made to enable and support them in their role of caring for an older person.		X				
Commentary 3.3.1 Computerised at Ayr. 3.3.2 *No evidence in the care plans in the acute wards. 3.3.3 This was patchy. Example Stroke 3.3.9 We saw little evidence in the care plans.							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Rehabilitation services provide a comprehensive range of facilities for older patients.							
3.4	Rehabilitation services provide a comprehensive range of facilities for older people.						
3.4.1	Rehabilitation should start as soon as possible after acute admission.		*	X			
3.4.2	There is a system of bed management in place to ensure efficient user of rehabilitation facilities.			X			
3.4.3	There is a defined and adequate area for rehabilitation (preferably contiguous with the acute hospitals)			X			
3.4.4	All patients are regularly reviewed by a Consultant-led, interdisciplinary team.			X			
3.4.5	There is a system of specialist stroke care.			X			
3.4.6	There is a system of specialist ortho-geriatric care.	*		X			
3.4.7	Systems are in place to ensure planned and organised discharges as appropriate.				X		
3.4.8	Adequate rehabilitation staff and assistants are employed to ensure comprehensive service delivery.		X				
3.4.9	Nursing staff in rehabilitation have a clearly defined role in patient rehabilitation.				X		
<p>Commentary</p> <p>In North Ayrshire there are delays in transfer to rehabilitation and no ortho-geriatric care.</p> <p>3.4.2 In North Ayrshire bed management does not always lead to efficient use of rehabilitation facilities.</p>							
PRINCIPLE: Respite care is provided according to need and identified good practice.							
3.5	Respite care provides a comprehensive needs assessment and health gain.						
3.5.1	The multidisciplinary team, using agreed local criteria between health and social work, assesses elderly people for respite.		X				
3.5.2	Patients with ongoing rehabilitation need complex medical or nursing needs or terminal illness will be considered suitable for planned NHS respite.			X			
3.5.3	On admission assessment of future needs will be carried out and discussed with carers.			X			
3.5.4	Planned respite will be notified well in advance to allow carers to book holidays.			X			
3.5.5	Emergency respite will be provided if appropriate.			X			
<p>Commentary</p> <p>We found no joint criteria and an over use of health facilities for social respite.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE Outpatient services are run efficiently for patients.							
3.6 Outpatient services are run efficiently for patients.							
3.6.1	There is a mechanism within the service for the fast tracking of urgent patient referrals; such patients to be seen within a week of receipt of referral by a Consultant Geriatrician.			X			
3.6.2	Non-urgent referrals are seen timeously, within 2-8 weeks.		X				
3.6.3	People attending for an outpatient appointment are seen without delay. Explanations are given if delays occur.			X			
3.6.4	Appointment times reflect patient and public transport services.			X			
3.6.5	Proposed treatments, including investigations, are started within 4 weeks of the first appointment. Services are arranged to ensure that there is no undue delay.		X				
3.6.6	Patients should have the choice of being accompanied by a relative, friend or advocate.			X			
3.6.7	GPs receive information about consultations and recommendations within one week of appointment.			X			
<p>Commentary</p> <p>3.6.2 There was variance between stated and actual waiting times.</p>							
3.7 There is a full range of outpatient clinics that meet the needs of the older person.							
3.7.1	There are TIA, falls, memory, movement disorders and other specialised clinics developed or being developed where volume and resources allow.			X			
3.7.2	Outpatient clinics are also available outwith the hospital setting, e.g. community hospitals and health centres.				X		
3.7.3	There is a full range of specialist nurses and therapists supporting outpatient clinics.			X			
<p>Commentary</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Day hospitals are provided to support both primary and secondary care of older people.							
3.8	Day hospitals provide a comprehensive system of care for elderly people in the community.						
3.8.1	Recommendations in the consensus document produced by the RSCP Glasgow, the RCP Edinburgh and BGS Scotland are referred to and adhered to.		X				
3.8.2	There is an efficient system for rapid review of patients.			X			
3.8.3	A system is in place for regular medical, nursing and PAM'S review of patients attending.				X		
3.8.4	Patients are kept fully informed of progress and results of investigations.			X			
3.8.5	A full range of treatment facilities including medical, nursing, PAM'S and investigations are available.		X				
3.8.6	Patients are fully and comprehensively assessed during their first two visits and there is evidence of goal setting and timeous discharge.			X			
3.8.7	Day hospital accommodation is conducive to patients' ease and comfort and provides a social and therapeutic environment.			X			
3.8.8	On discharge from day hospital, full information is given to the GP and given to patients/carers.			X			
<p>Commentary</p> <p>There is a wide variety of day hospital provision and some inappropriate use and under use in others. We saw no evidence that the service had been reviewed using the consensus document.</p>							
PRINCIPLE: Continuing care is provided according to need and identified good practice near to the patient's home or relative.							
3.9	Recommendations in the consensus document on long term care produced by the RCPS Glasgow, the RCP Edinburgh and the BGS should be adhered to.						
3.9.1	Prior to admission, a multi-agency/multidisciplinary assessment is undertaken.			X			
3.9.2	On admission, multidisciplinary assessment is holistic and identifies the individual's current medical, social, nursing, function, psychosocial and emotional needs.			X			
3.9.3	The reasons for admission are stated (e.g. NHS continuing care, palliative care, awaiting placement to residential/nursing home care).			X			
<p>Commentary</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
3.10	Older people requiring continuing care are able to make an informed decision with their families and/or carers about future care arrangements.						
3.10.1	Patients enter continuing care only after assessment and care planning with relatives/advocate.			X			
3.10.2	Patients are provided with clear information and encouraged to visit potential care homes.		X				
3.10.3	Care is provided as near to the patient's home or relative as possible.			X			
<p>Commentary</p> <p>3.10.1 There is no advocacy service.</p> <p>3.10.2 Only relatives are encouraged to visit.</p> <p>3.10.3 There are delays in some areas due to lack of local services.</p>							
3.11	Regular reviews are carried out in NHS continuing care to ensure that the arrangements made continue to be appropriate and satisfactory.						
3.11.1	Patients have a multidisciplinary review of physical, mental health and prescribed medication with involvement of family/carers as appropriate at not less than six monthly intervals or more often for those with changing needs.			X			
3.11.2	Patient needs for special facilities and equipment are met.		X				
3.11.3	Patients should have the choice of single room accommodation of nursing home standard that is 'homely'.		X				
3.11.4	Patients with rehabilitation potential and/or a need for maintenance/diversional therapy have their needs met.			X			
<p>Commentary</p> <p>3.11.1 Assessment form has no functional assessment and a uniform tool should be used.</p> <p>3.11.2 There was a shortage of wheelchairs in Ayr Central Hospital and a general lack of variable height seating. Some services reported a lack of specialist eating utensils.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: Palliative care is provided according to need and identified good practice.							
3.12 Arrangements for providing palliative care take full account of the needs and wishes of users, their families and carers.							
3.12.1	Patients and carers are fully informed about their illness, to the level desired by the patient and about the range of options for their care, including hospice, community hospitals and at home.				X		
3.12.2	There is a multi-agency agreement available for care at home.				X		
3.12.3	Staff can arrange for patients to receive the advice they want and need if they are not able to provide it themselves, for example spiritual support.				X		
3.12.4	Privacy is afforded to the dying patient, their family and carers; single room accommodation is readily available.				X		
Commentary							
3.13 Staff have the ability to meet the needs of the patient and family at all stages of their illness.							
3.13.1	There is access to specialist advice from a palliative care team 24 hours a day.				X		
3.13.2	Specific training in palliative care is available.				X		
3.13.3	Staff are familiar with the use of syringe drivers and these are readily available.				X		
3.13.4	Agreed protocols are available.				X		
Commentary The service is good and supported with policies and palliative care manual.							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: The Trust has corporate accountability for clinical performance.							
3.14	There are clear lines of responsibility and accountability for the overall quality of clinical care within the Trust.						
3.14.1	Each Trust has a senior clinician responsible for ensuring that structures and systems to support clinical governance are in place and are effective.				X		
3.14.2	A Trust Clinical Governance Board is in place.				X		
3.14.3	All staff within the Trust are aware of and understand their role, responsibility and accountability for clinical governance.			X			
3.14.4	The Trust has a comprehensive programme of quality improvement activities.				X		
3.14.5	The Trust has a documented plan that outlines the quality management and improvement programme.				X		
3.14.6	Effective quality monitoring systems have been established to collect and report on clinical information.				X		
3.14.7	Clear communications structures exist.				X		
3.14.8	The Trust produces an annual report on clinical governance.				X		
Commentary							
3.15	Clinical audit, research and development and practice development plans support the clinical governance framework.						
3.15.1	The Trust has a research and development strategy.				X		
3.15.2	The Trust has a policy and/or guideline, which clearly identifies the responsibility for agreeing and evaluating areas of practice.				X		
3.15.3	The Trust has a structure in place to support clinicians to undertake research and development projects and to implement the findings of research.			X			
3.15.4	Systems are in place for reviewing and improving practice against national guidelines and reports such as SIGN and CRAG.				X		
3.15.5	The Trust has a structure in place to raise staff's awareness, agree and co-ordinate clinical audit projects.				X		
3.15.6	Clinical staff participate in clinical audit programmes both at a local and national level.			X			
3.15.7	The Trust has a system in place to communicate and implement the findings of clinical audit.				X		
Commentary							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
3.16	The Trust has clear policies aimed at managing risks.						
3.16.1	Programmes are in place to identify trends, monitor and report on areas of risk.			X			
3.16.2	Corrective action plans are developed and implemented within the Trust to reduce risk including: lifting and handling, food hygiene, health and safety plan, departmental hygiene and cleanliness, management of falls, management of aggression/restraint, discharge planning, bed management and tissue viability.			X			
<p>Commentary</p> <p>This could be an area for further development as we saw little evidence of corrective action plans in some areas e.g. the tissue viability audit has no action plan.</p>							
3.17	The Trust has clear procedure in place which enable all professional groups to identify and improve areas of poor performance.						
3.17.1	A system of critical incident reporting is established which ensures adverse events are identified, openly investigated and improvements made where necessary within an agreed timescale.			X			
3.17.2	A complaints procedure is in place which reflects national guidance and is both easily accessed by patients and their families and is fair to staff.				X		
3.17.3	The Trust has established a culture that enables them to learn from and initiate improvements to the service as a result of formal and informal complaints at all levels of the organisation.				X		
3.17.4	Professional performance procedures are in place and understood by all staff.				X		
3.17.5	Clear procedures are in place to support staff in their duty to report any concerns about a colleague's professional conduct and performance so that early action can be taken to support the individual to remedy the situation.			X			
3.17.6	The Trust has established clinical supervision and peer review systems throughout the organisation.			X	*		
<p>Commentary</p> <p>3.17.6 Well developed in the Acute Trust.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
3.18	The Trust is committed to the continual training and development of staff to meet its service objectives as outlined in the Trust Implementation Plan and within the financial constraints of the organisation.						
3.18.1	The Trust has a system in place to ensure all staff employed by the organisation hold the relevant professional qualifications for their post.				X		
3.18.2	A system and structure is in place which facilitates the continuing training and development of staff.				X		
3.18.3	The Trust has a clear structure in place for overseeing and reporting on the training and development of staff.			X			
3.18.4	The Trust has a training and development plan which links to the Trust Implementation Plan and reflects the training and development needs of staff and finance available to resource it.			X			
3.18.5	Each member of staff has a personal training and development plan linked to the Trust Implementation Plan and which reflects their current role within the organisation.			X			
3.18.6	The Trust has systems in place to ensure that practice is improved and sustained as a result of training.			X			
3.18.7	Training courses run by the Trust are reviewed to reflect the findings of evaluation.			X			
3.18.8	The Trust has established networking processes on an internal and national basis to facilitate the sharing of good practice.			X			
Commentary 3.18.4/5 We saw no evidence of a training plan for staff in services for older people.							

Quality Indicator 4 Quality Of Life		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
PRINCIPLE: The individual patient's quality of life is maintained							
4.1	The patient has privacy protected and maintained in their personal space, living areas, belongings and personal financial affairs.						
4.1.1	The patient: Is enabled to eat, bathe, use the toilet and receive care in private.		*	X			
4.1.2	Is able to entertain family, friends and visitors in private.		X				
4.1.3	Is free to be alone when it is wished.		X				
4.1.4	Is allowed to choose where meals are eaten.		X				
4.1.5	Is consulted as to who has access to his/her personal/confidential/medical records.			X			
4.1.6	Has access to any record kept.			X			
4.1.7	Nursing practice will demonstrate the patient's rights to privacy and dignity.			X			
4.1.8	Doors and windows will be closed to ensure privacy; screening facilities will be available in communal areas.			X			
Commentary Use of commodes and toilet curtains undermines this. 4.1.2/3/4 Sometimes due to the accommodation restrictions on choice are in place.							
4.2	The patient is assisted to achieve a level of autonomy and self determination compatible with their wishes and abilities.						
4.2.1	The patient: Is encouraged to maintain control over his/her own affairs (lifestyle, financial, legal, medical).			X			
4.2.2	Is given opportunities to incur a degree of calculated risk.			X			
Commentary							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
4.3	The patient has a range of choices available.						
4.3.1	The patient is offered choice in all aspect of daily living.			X			
4.3.2	When unable to make individual decisions, the patient has access to an independent advocate.	X					
4.3.3	Patients wear their own clothing.				X		
Commentary The use of a choice proforma is good. There is no advocacy.							
4.4	The patient has the right to maintain a fulfilling and interesting lifestyle within and outwith the ward.						
4.4.1	The patient: Is able and encouraged to take part inpatient and other support groups.		X				
4.4.2	Has opportunities to maintain and develop own interests.			X			
4.4.3	Is free to participate or not as is wished.			X			
4.4.4	Is supported in maintaining his/her civil rights (e.g. voting at elections).			X			
4.4.5	Has views taken into account as to how the ward is run.	X					
Commentary 4.4.1/5 We saw little evidence of ward and support groups.							
4.5	The patient has the right to expect that cultural and spiritual beliefs shall be respected.						
4.5.1	The patient: is enabled to choose to participate in cultural and spiritual activities.			X			
4.5.2	will be able to maintain links with his/her community.			X			
4.5.3	has the right not to participate.			X			
4.5.4	will have their religious beliefs recorded in their care plan.				X		
4.5.5	Staff will offer assistance to ensure religious practices are met and access is given to appropriate representatives.				X		
4.5.6	Local religious service times and venues will be readily available on the ward.			X			
Commentary							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
4.6	The patient feels valued, contented and fulfilled, and can pursue social and leisure activities of their choice.						
4.6.1	The patient: has a fulfilling life with opportunities to give, receive and do.		*	X			
4.6.2	has the offer of diversional therapy.		*	X			
4.6.3	has security and confidence.			X			
4.6.4	has the opportunity to continue/establish meaningful, interpersonal relationships.			X			
<p>Commentary</p> <p>Diversional therapy is not available in all hospitals. Care plans for leisure, activities and preferences should be translated into lifestyle plans.</p>							
4.7	The patient will be moved safely and in a manner that suits their individual needs, ensuring safe practice.						
4.7.1	The patient will have a detailed plan of moving and handling risk assessment.				X		
4.7.2	Aids will be used as indicated in the plan.				X		
4.7.3	All staff will have instruction and training on the principles of moving and handling and the use of aids.			X			
4.7.4	Information on lifting and handling is available on each ward.				X		
4.7.5	The security, comfort and dignity of patients will be promoted whilst being moved.			X			
<p>Commentary</p>							
4.8	Voluntary activities are provided to enhance the quality of life of patients.						
4.8.1	The use of volunteers will be encouraged.			X			
4.8.2	There is a policy on the use of volunteers.			X			
4.8.3	There is a written induction programme.			X			
4.8.4	An identified person at ward level will communicate regularly with volunteers.			X			
4.8.5	All staff are aware of the procedure for recruiting volunteers.			X			
4.8.6	Patients will have their involvement in volunteer activity recorded in their notes.	X					
<p>Commentary</p> <p>4.8.6 We saw no evidence of this in the care plans.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
4.9	The interior of each living area will resemble that of domestic living conditions.						
4.9.1	Furnishing and fabrics will promote the general appearance of rooms and a homely atmosphere.		X				
4.9.2	The décor of each ward will be well maintained.		X				
4.9.3	Staff will ensure that furnishings and fabrics reflect the needs of patients.		X				
4.9.4	Redecoration plans include patient involvement.		X				
4.9.5	Staff and patients will be encouraged to share and enjoy a comfortable environment.		X				
Commentary							
4.10	Staff will be aware of patients who have a form of visual impairment and will ensure that care reflects their needs.						
4.10.1	Nursing and medical assessments will identify patients with visual difficulties.			X			
4.10.2	Each patient with a visual impairment will have their sight assessed every two years by an optician.			X			
4.10.3	All patients assessed as blind will be referred for specialist services and equipment.			X			
4.10.4	The ward environment will be conducive to maximising the individual's independence.		X				
4.10.5	Spectacles and aids are kept in good order.			X			
Commentary							
4.11	Staff will be aware of patients who have any form of hearing impairment.						
4.11.1	Patients with hearing loss will be identified and audiologically screened.			X			
4.11.2	Audiometric test results will be recorded in patients notes.						X
4.11.3	Patients who require hearing aids will have one that is in good repair, working and switched on.			X			
4.11.4	There will be individual care plans for patients that reflect their need for aids and communication methods used.			X			
Commentary							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
4.12	Patients who have difficulty in communicating through speech impairment will be cared for in a manner that reflects their individual needs.						
4.12.1	Patients with speech impairment will be identified at assessment.			X			
4.12.2	Each patient will be referred as appropriate to a speech therapist.			X			
4.12.3	Assessment results and aids required will be documented in a patient's care plan.			X			
4.12.4	Staff will receive instruction that will allow them to communicate effectively with patients.		X				
4.12.5	Each patient will have a communication system that meets and suits their individual needs.		X				
<p>Commentary</p> <p>There is a general lack of sensory impairment aids on the wards e.g. no communication aids for deaf patients.</p>							
4.13	Patients who are not continent will have the same life opportunities as patients who are continent.						
4.13.1	Patients will have their individual needs assessed and recorded in an individual care plan.		*		X		
4.13.2	Each patient will be supplied with the aids necessary to promote self esteem and dignity, these will be used in a manner not to draw attention to incontinence.		*	X			
4.13.3	Staff will provide support and assistance.			X			
4.13.4	Staff will ensure the environment and atmosphere of the ward is of an acceptable standard.		*	X			
<p>Commentary</p> <p>4.13.1 In the Orthopaedic wards in Crosshouse Hospital there is no use of a continence assessment tool.</p> <p>4.13.2 There is an overuse of commodes.</p> <p>4.13.4 Carpets at Biggart Hospital are smelly.</p>							
4.14	Patients who require assistance with mobility will be provided with appliances and wheelchairs designed for their personal use, whilst promoting mobility, comfort, dignity and self esteem.						
4.14.1	Patient's mobility is assessed and recorded in individual care plans.				X		
4.14.2	Patient's aids and wheelchairs are discreetly marked with their name.			X			
4.14.3	Staff will be aware of how to use and maintain aids and wheelchairs.				X		
<p>Commentary</p> <p>The wheel chair audit is very good and the guidance for staff.</p>							

		Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
4.15	Each patient will be treated with courtesy and respect.						
4.15.1	Staff will respect the patient's right to courtesy.				X		
4.15.2	Agreed forms of address will be recorded in the care plan and will conform to age and gender appropriate terms.				X		
4.15.3	Courtesy will be extended to all relatives, carers and friends of patients.				X		
Commentary							
4.16	Each patient will have his or her nutritional needs met by a healthy diet.						
4.16.1	Each patient will have a varied nutritionally balanced diet, which takes account of his or her personal choices.				X		
4.16.2	Patients will choose from the daily menu.				X		
4.16.3	Patient's preference will be recorded in care plans.				X		
4.16.4	Each patient will be assessed using a nutritional assessment tool and referred for specialist advice and feeds.				X		
4.16.5	Patient's weight will be monitored weekly and appropriate action taken when loss is noted.				X		
4.16.8	There is evidence on the ward of specialist diets, PEG feeds when appropriate and the use of dietary supplements.				X		
Commentary							

		Quality Indicator 5					Strongly Disagree	Disagree	Agree	Strongly Agree	Not Relevant	Don't Know
		Planning and Assessing Need										
PRINCIPLE:		A needs assessment is undertaken that informs the strategic direction of the service										
5.1		There is a programme of health needs assessment undertaken by the NHS Board in partnership with Trusts, Local Authorities and users and carers.										
5.1.1	NHS Boards include the needs of older people in Health Improvement Plans.							X				
5.1.2	NHS Boards have identified specialist service needs and have service agreements in place to access services where appropriate.							X				
Commentary												
5.2		The NHS Board has a written plan for health care provision for older people.										
5.2.1	The plan has been agreed with partners and is publicly available.						X					
5.2.2	There is financial investment in services for local needs.						X					
Commentary The plan is in draft and out for consultation.												
5.3		NHS Boards utilise up-to-date, evidence-based outcome and health gain information in their decision making.										
5.3.1	Clinical guidelines are available.							X				
5.3.2	Evidence based information is adopted.							X				
5.3.3	Decision making systems are open to the public and professions.							X				
Commentary												
5.4		The Trust has a clear strategy, which outlines its service objectives over a five-year period and takes cognisance of the needs of the population that it serves.										
5.4.1	The Trust Implementation Plan links to the NHS Board's Strategy for Older People and priorities identified by the multi-agency planning partners.						X					
5.4.2	Staff participate in the development of the Trust Implementation Plan.							X				
5.4.3	A clear communications structure is in place, which enables staff to participate in the development and review of the strategy enabling feedback in relation to progress in its implementation.								X			
5.4.4	Staff are fully aware of their role in relation to the implementation of the Trust's strategy.							X				
Commentary The strategy for older people is well known by staff who have been briefed and consulted.												

Services Visited

<u>Hospital</u>	<u>Ward/Service</u>	<u>Function</u>
South Ayrshire Service		
Ayr Hospital	A&E and 3 wards.	Assessment and rehabilitation general medicine and orthopaedics.
Biggart Hospital	6 wards and Day Hospital	Assessment/rehabilitation, stroke and continuing care.
East Ayrshire Community Hospital	2 wards, day hospital and outpatients.	24 GP beds, 20 continuing care beds and 5 respite and 12 day hospital places.
Holmhead Hospital	2 wards	Continuing care
Davidson Cottage Hospital	1 ward and day hospital	GP
North Ayrshire Service		
Crosshouse Hospital	A&E and 6 wards	Acute medical admissions, orthopaedics, assessment and rehabilitation and stroke.
Ayrshire Central Hospital	4 wards and Douglas Grant Day Hospital	Assessment and rehabilitation, stroke and continuing care.
Kirklandside Hospital	Four wards and a day hospital 85 beds and 12 places.	Continuing care, intermediate care and day hospital.
Brooksby Hospital	1 Ward and day hospital.	18 continuing care beds

Lady Margaret Hospital			1 Ward, 4 place Day Hospital, Outpatients and casualty.	GP beds and elderly day patients
Arran Hospital	War Memorial		20 general GP beds and 2 maternity, A&E, theatre, outpatients and rehabilitation.	GP and maternity.
Arran Home	View Nursing		2 wards	Continuing care.

Departments and Groups

Executive Trust Management Teams

Ayrshire and Arran NHS Board

North, South and East Ayrshire Council Social Work Services

Local Health Care Cooperative teams

Consultants, junior doctors, nurses, specialist nurses and nurse managers and AHPs

Quality development and clinical governance teams

Hospital social workers and discharge teams

Service users and carers

Voluntary Groups including WRVS Hospital Volunteers, Disability Forum, Patient's Council, Hospital Chaplain, Senior Nurse Public Patient Involvement and League of Friends Princess Royal Carers, and Local Health Council, Help the Aged Stroke Support and Hospital Volunteers.

Advocacy service

Community services

LHCC Teams/GPs

Integrated Care Team

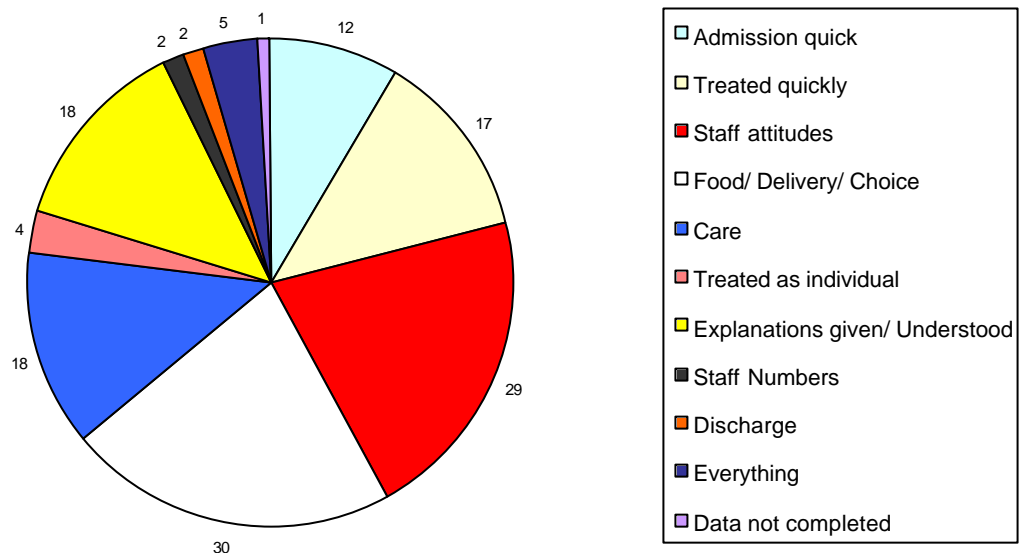
Social workers and discharge teams Rapid Response Teams and Discharge co-ordinator.

District nurses and health visitors

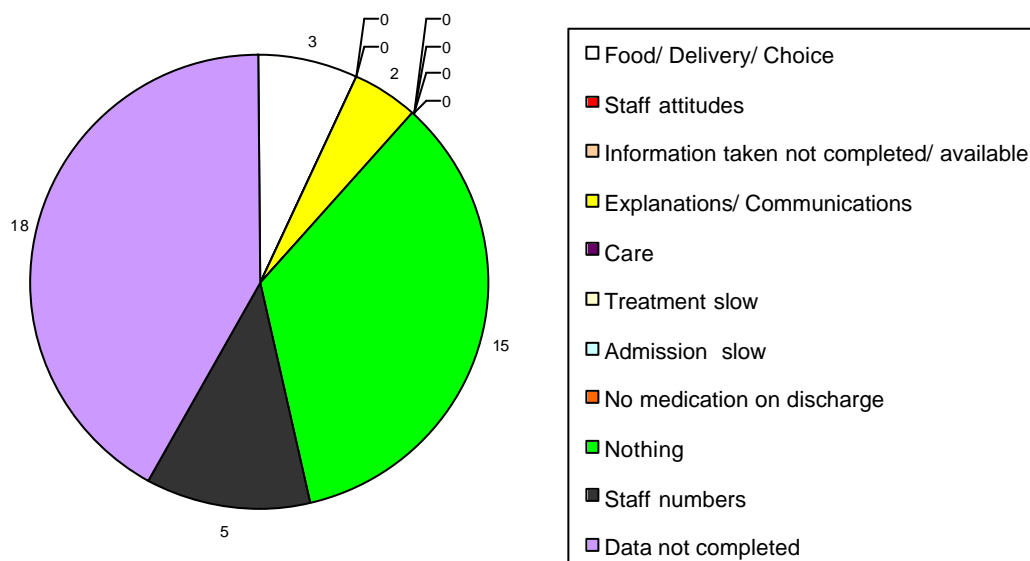
User and Carer Questionnaire Charts

42 questionnaires were returned by service users, carers and relatives in Ayrshire and Arran. Respondents were asked to indicate what they thought was good and what could be improved. The numbers in the graphs relate to responses to each part of each question.

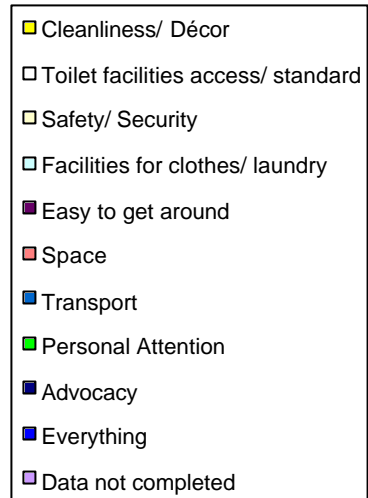
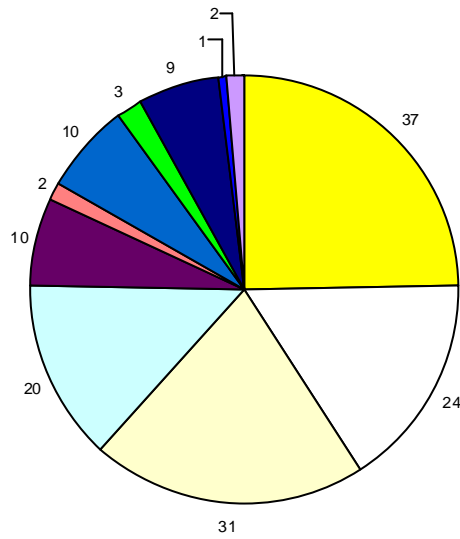
What was good about what happened in hospital?



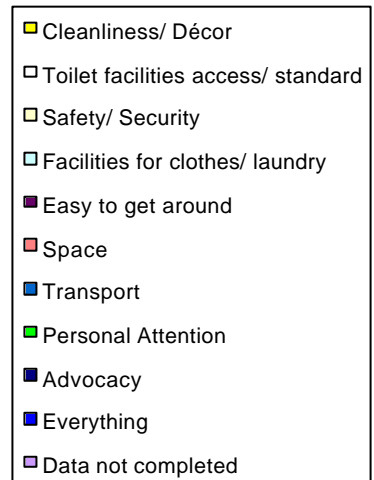
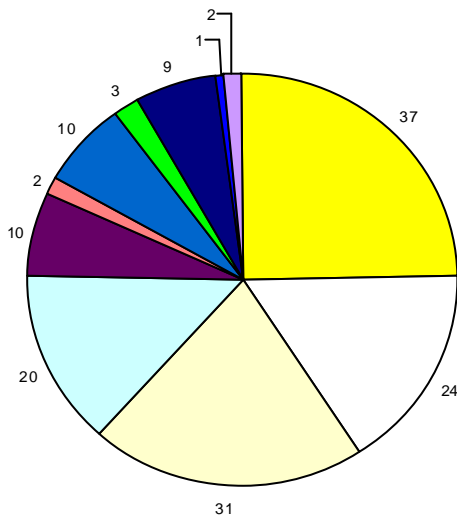
What could be done better in hospital?



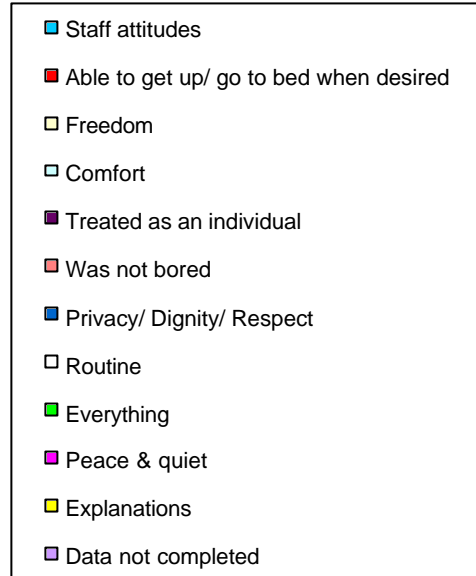
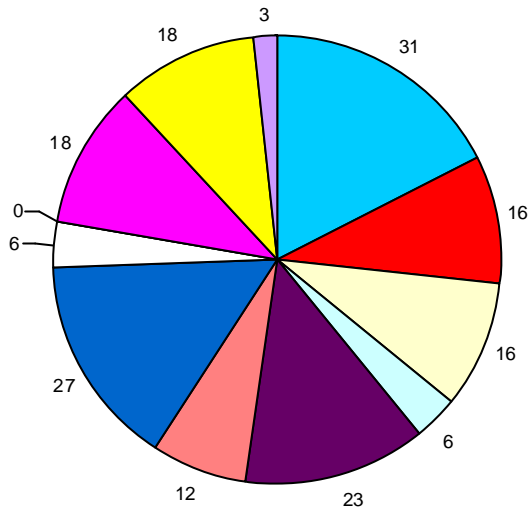
What was good about the support services in hospital?



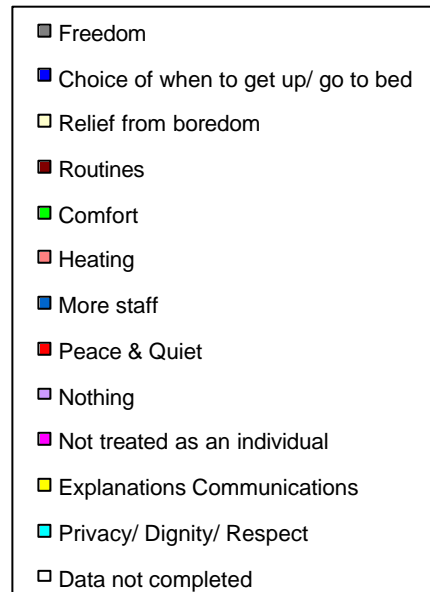
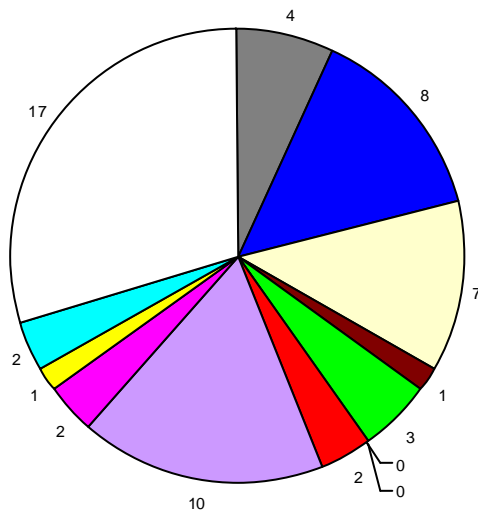
What was good about the support services in hospital?



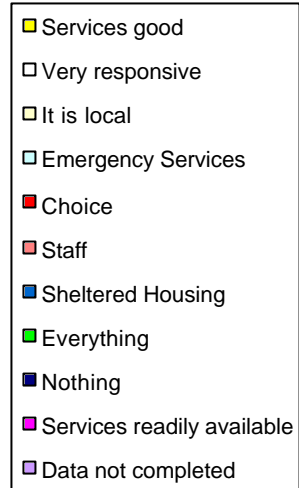
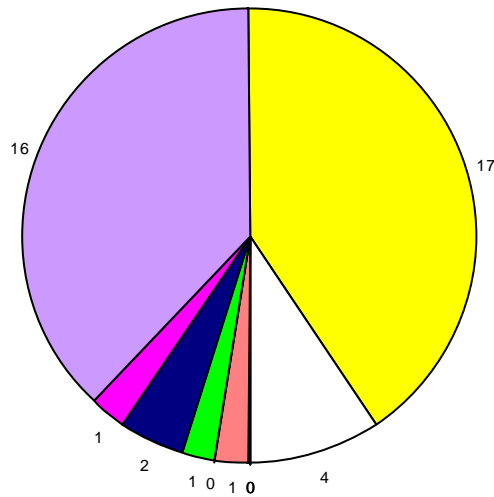
Home - v - Hospital - What was good?



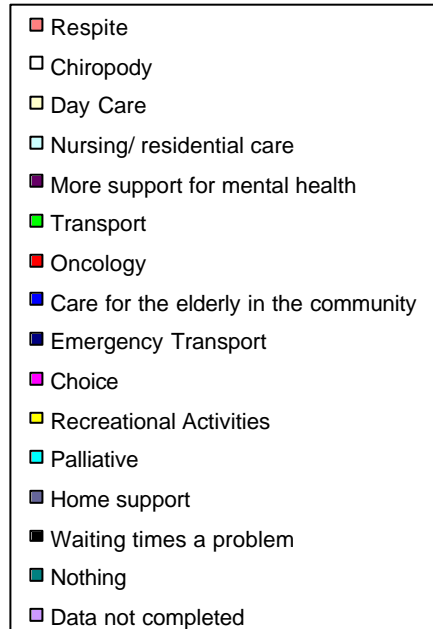
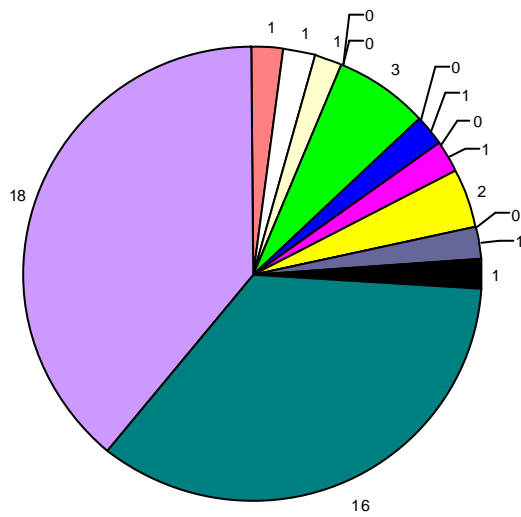
Home - v - Hospital - what could be improved?



What's good about health services locally?



What services are missing locally?



Glossary

Acute services	Medical and surgical interventions and emergency care are provided in hospital.
Advocacy	A support system for helping people to say what they need, to make choices and to make their own decisions.
Advocate	Someone who is independent of the service providing care. The advocate represents the needs of the service user and supports them to make sure they are able to make choices and get the rights to which they are entitled.
Acute Trust	Established on 1 April 1999 as part of the Designed to Care arrangements. Responsible for a defined set of acute hospital services within the geographical boundary of individual NHS Boards. Usually no more than one in each NHS Board area.
AHPs	Allied Health Professionals (formerly Professions Allied to Medicine) including physiotherapy, occupational therapy, speech and language therapy, chiropody, pharmacy, radiography, dietetics, orthoptics, art, music and drama therapies.
CASPE	Clinical Accountability, Service Planning and Evaluation. A process of accreditation for community hospitals.
Clinical governance	A framework through which NHS organisations are accountable for continuously improving the quality of services and safe-guarding high standards of care. This involves auditing and monitoring the quality of care and making necessary improvements.
CNORIS	Clinical Negligence and Other Risk Indemnity Scheme – a risk management scheme, membership of which is obligatory for all NHS Trusts and Boards in Scotland.
Commissioning	Making the decision on what services are needed and then contracting with a statutory or voluntary organisation to provide them.
Consensus statement	An agreed statement by a group of professionals.
Continuing NHS care	Nursing and/or medical help of a level that cannot be provided in a nursing home (now called a care home) so that the person needs to remain in hospital.

CRAG	Clinical Resource and Audit Group. Established in 1989, to provide advice to Scottish Executive Health Department on the development of policies on clinical effectiveness and to develop and fund a programme of work to support the clinical effectiveness agenda. Now part of NHS Quality Improvement Scotland.
CSBS	Clinical Standards Board for Scotland – Established as a Special Health Board on 1 April 1999 to develop a national system of quality assurance of healthcare services in Scotland. Now part of NHS Quality Improvement Scotland.
Day services	A facility where patients receive treatment and can participate in social activities on a daily basis.
Delayed discharge	A delayed discharge is experienced by a person in hospital who is clinically ready to move to the next stage of care but is prevented from doing so by one or more reasons for delay in discharge.
Dementia	An illness that affects the brain and usually causes symptoms such as confusion and loss of memory.
Diversional therapy	Programmes available to patients to ensure that they are physically, mentally and socially stimulated.
Joint Community Care Plan (JCCP)	A written specification and commitment to provide care for people in the community. It is developed jointly by local authority social and housing services, health services and voluntary organisations.
Lifestyle plans	Personal lifestyle plans link a person's life before they became ill with the future plans for care, to ensure that personal likes, dislikes and preferences are taken into account (including when resident in hospital).
LHCC	Local Health Care Co-operatives are voluntary groupings of GPs and other local health care professionals intended to strengthen and support the primary health care team in delivering local care. LHCCs are part of the management structure of the Primary Care Trust and no legislative provision is required to establish them. There are 70 LHCCs in Scotland, based on natural communities. The exact scope of each LHCC is determined by agreement among member practices and the PCT management.
Named nurse	A registered nurse who is responsible for assessing, planning, implementing, evaluating and co-coordinating patient care on an individual basis from admission/transfer to transfer/discharge.

Neuroleptic drugs	Antipsychotic drugs that generally tranquillise without impairing consciousness.
OT	Occupational Therapy/Therapist. Occupational therapy helps people live more productive and enjoyable lives. It's a way of helping individuals to do the things they want and become much more independent.
Palliative care	Holistic care for someone who is not going to get better.
Picker Satisfaction Survey	A survey tool developed by the Picker Institute, which works with European health care providers to survey patients' experience and promote patient-centred care.
Primary care	Family health services provided by GPs, nurses, dentists, pharmacists, optometrists and ophthalmic medical practitioners.
Primary Care Trust (PCT)	Established in Scotland from 1 April 1999 with responsibility for the provision of primary care, community, and mental health services. There is usually one PCT in the geographical area of each NHS Board.
'As required' prescribing	Prescribed medicines that can be given by a nurse as required.
Respite care	Respite care is available in health and social care settings and at home so that the patient and the carer can have a short break.
Secondary care	Care that is provided in acute hospitals and psychiatric hospitals, usually on referral from primary care. The term applies to outpatient specialist services also.
SHRUGS	Scottish Health Resource Utilisation Groups. Information system that describes patients in continuing care in a way that is predictive of resource use.
SIGN	Scottish Intercollegiate Guideline Network(s). This was set up in 1993 and is funded by the Clinical Resource and Audit Group (CRAG) as a collaborative venture undertaken by the Scottish Royal Colleges and other health professionals to sponsor and support the development of national clinical guidelines on a multi-professional basis.
Strategy	Sets out the vision for how particular health services will be delivered in the future.
Stroke	A term for either a blood clot or a bleed in the brain that causes loss of use or sensation down one side of the body.

Telford

A consultative method of assessing staffing levels using the professional judgement of ward managers and staff.

TIA

Transient Ischaemic Attack. A condition similar to but less severe than a stroke, in which the symptoms are short lived.

Key Documents

Independent Advocacy – A Guide for Commissioners, November 2001, Scottish Executive

Community Care: A Joint Future – Report of the Joint Future Group, November 2000,
Scottish Executive

Staff Governance Standard for NHSScotland Employees, 2002, Scottish Executive

Strategy for Carers in Scotland, November 1999, Scottish Executive