

Best Practice Statement ~ *January 2004*

Working with Older People Towards Prevention and Early Detection of Depression



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Introduction

NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board on 1 January 2003 as a result of bringing together the Clinical Resource and Audit Group (CRAG), Clinical Standards Board for Scotland (CSBS), Health Technology Board for Scotland (HTBS), Nursing and Midwifery Practice Development Unit (NMPDU) and the Scottish Health Advisory Service (SHAS).

The purpose of NHS QIS 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.

Background to Best Practice Statements

While many examples of clinical guidelines exist there is a lack of reliable statements focusing specifically on nursing and midwifery practice. The development of best practice statements reflects the current emphasis on delivering care that is patient centred, cost-effective and fair, and will attempt to reduce existing variations in practice. The common practice that should follow their implementation will allow comparable standards of care for patients wherever they access services.

What is a Best Practice Statement?

A best practice statement is a statement to describe best and achievable practice in a specific area of care. The term 'best practice' reflects the commitment of NHS QIS to sharing local excellence at national level. Best practice statements are underpinned by a number of shared principles (page ii).



Key Principles of Best Practice Statements

- Best practice statements are intended to guide practice and promote a consistent and cohesive approach to care.
- Best practice statements are primarily intended for use by registered nurses, midwives and the staff who support them, but they may contribute to multidisciplinary working and other members of the healthcare team may find them helpful.
- Statements are derived from the best available evidence at the time they are produced, recognising that levels and types of evidence vary; where a statement is developed in the absence of research evidence and is predominantly based on consensus this will be noted.
- Information is gathered from a broad range of sources in order to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature and establish consensus.
- Statements are targeted at practitioners, using language that is accessible and meaningful.
- Consultation with relevant organisations and individuals is undertaken.
- Statements are reviewed and updated every 3 years.
- Responsibility for implementation of statements rests at local level.
- Key sources of evidence and available resources are provided.

Key Stages in the Development of Best Practice Statements

A unique feature of the Gerontological Nursing Demonstration Project Best Practice Statements is that they are refined through evaluative research to enhance practice utility.

Review Evidence

Research, major reports, national audits, existing care guidance, expert nursing opinion, evidence from older people.



Draft Best Practice Statement

Identify nursing contribution, apply gerontological nursing values, identify level and type of evidence.



Pilot within a Demonstration Site

Base-line audit, facilitate practice development and problem solve, involve users, pool expertise of gerontological link nurses, refine statement, follow-up audit. External consultation for the revised draft.



Disseminate and Update 3-yearly

Paper copies, on-line in PDF format, face to face seminars, e-based practice facilitation with link nurses.

Promote networking between link nurses, demonstration site staff and practitioners involved in progressing implementation.



Who was Involved in Developing the Statement?

Steering Group

Duncan Clarkson	Gerontological Link Nurse Network Based in the Borders
Andy Lowndes	Practice Development Fellow Equal Project, Glasgow Caledonian University
Mandy McFadyan	Gerontological Link Nurse Network Based in Glasgow
Donna Morrison	Gerontological Link Nurse Network Based in Dundee
Valerie Provan	Quality & Effectiveness Co-ordinator, Ayrshire & Arran Primary Care NHS Trust, Expert Advisor
Irene Schofield	Research Fellow in Gerontological Nursing, Glasgow Caledonian University
Ria Tocher	Gerontological Link Nurse Network Based in Edinburgh
Debbie Tolson	Professor of Gerontological Nursing, Glasgow Caledonian University

Demonstration Site Staff

Mary Dowds, Regional Training Officer, Ashbourne Homes
Lisa Hilditch, Senior Carer, Eastwood Court Nursing Home
Liz Hotchkiss, Deputy General Manager, Eastwood Court Nursing Home
Mary Macgee, General Manager and Divisional Nurse, Ashbourne Homes
Sandra Stark, Director of Nursing and Quality, Ashbourne Homes
Isobel Steele, Activities Organiser, Eastwood Court Nursing Home
The staff and residents of Eastwood Court Nursing Home

Nurse Reference Group

Scottish Gerontological Link Nurse Network (see Appendix 2)

How Can the Statement be Used?

The recommended best practice statement can be used in a variety of ways, although primarily it is intended to promote evidence based nursing practice. The statement is intended to be realistic but stretching and can be used:


- as a basis for developing and improving the care that nurses give to older people;
- to stimulate learning amongst teams of nurses;
- to promote effective interdisciplinary team working;
- to determine whether a quality service is being provided; and
- to stimulate ideas and priorities for nursing research.

Best Practice Statement on Working with Older People Towards Prevention and Early Detection of Depression

This best practice statement has been produced by NHS QIS to offer evidence based nursing guidance on prevention and early detection of depression in older people. In particular the best practice statement informs care of older people who are moving to continuing care facilities such as community hospitals or care homes (nursing), older people awaiting hospital discharge or experiencing delayed discharge, or a comparable period of instability in their lives.

Snowdon (1998) describes depression as “a collective term referring to disorders in which the central feature is a lowering of mood, usually accompanied by reduced ability to enjoy or take interest in one’s usual activities (p.57)”. The condition often goes unrecognised in older people, and it has been suggested that up to 40% of people who live in a care home or continuing care ward suffer from depression (Audit Commission, 2000; Brown et al, 2002).

The causes of depression can be categorised as external and internal. External causes include negative reactions to life events such as bereavement, chronic ill health, giving up one's home and the side-effects of medications. Internal causes include hereditary susceptibility, deficiency disorders, hormonal changes or imbalances (Matthew, 1996). Responses to life events involving loss and change inevitably lead to feelings of low mood and reactive sadness for most people, and given time they ‘work through’ the feelings and emotions associated with such events. This best practice statement has been developed to demonstrate



how nurses can begin to work with older people and their families at times of critical change in order to provide support and to prevent the normal responses to loss and grief from developing into clinical depression.

The statement has been developed collaboratively by the Gerontological Nursing Demonstration Project research team (Glasgow Caledonian University), the Scottish Gerontological Link Nurse Network (Appendix 2), NHS QIS, and staff and residents at Eastwood Court Nursing Home and Ashbourne Homes. It is for the use of nurses and care teams and provides information for older people and their families. Readers who want to audit their own practice might wish to modify the comprehensive audit instrument that was used in the demonstration site. This can be seen on the website (www.geronurse.com).

The Gerontological Nursing Demonstration Project

This practice innovation research project involves the development of best practice statements, which are informed by a review of existing evidence and refined through testing and user involvement in a Demonstration Site. The presentation of the statement reflects the emerging definition of gerontological nursing, and an agreed set of values developed by the Scottish Gerontological Link Nurse Network. The statement reflects the beliefs of nurses and has been demonstrated to be achievable within practice areas similar to the demonstration site. To see the definition and list of values refer to Appendix 3; alternatively you may wish to find out more about the project by visiting the website (www.geronurse.com).

How was the Best Practice Statement on Working with Older People Towards Prevention and Early Detection of Depression Developed?

Evidence from major research studies, audit reports, existing standards, guidelines and committee reports has been reviewed by an Expert Advisor guided by a team of expert practitioners and researchers. Members of the Scottish Gerontological Link Nurse Network (Appendix 2) have assisted in the identification of the nursing contribution and in ensuring that the statement reflects their beliefs about the nursing care of older people. Groups representing the interests of older people and older people themselves have contributed to the process. The statement has already been tested and revised within a Scottish care home.

What is the Evidence Base?

All recommendations are evidence based. The level and type of evidence, which informs the statements, is denoted using SIGN criteria. In just under half of cases the type of evidence used to support the recommended best practice is that obtained from expert committee reports. This is designated as level 4 type evidence (SIGN, 2001). The evidence is given an overall grade recommendation of 'D'. One third of the cases are designated level 3 and the remainder at level 2. You can see the other levels of evidence and grading criteria in Appendix 4.

Who is the Statement For?

The recommended best practice statement is primarily for the use of registered nurses. However, other members of the professional healthcare team may find them helpful in understanding the nurse's contribution to overall care, and in particular understanding the contribution which skilled nurses can make to the health of older people. The statements have been written in accessible language so that care staff, older people, and their families or carers can understand them and contribute to evaluation.

References

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Further information

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Section 1: Promoting Nurses’ Awareness of Depression in the Older Person

Key Points ~

1. *Depression can occur as a response to loss and change.^{1,5}*
2. *Nurses have a key role in identifying the older person at risk of depression.²*
3. *The transition to long-term care involves anticipation of the move, moving in and adjusting to a new way of living⁹*
4. *The presentation of depression in older adults may be altered, and complaints of troublesome physical symptoms may be a sign of depression.^{1,10}*

[The numbers above the text correspond with the sources of evidence in Appendix 1]

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Nursing staff are aware of the impact of ongoing and changing health and life circumstances on the mental wellbeing of older people, including their vulnerability to depression.²</p>	<p>There is evidence that the following life and health changes can affect the mental wellbeing of older people:</p> <ul style="list-style-type: none"> ● The move into a care home^{9, 10} and moves between types of institutional care have been identified as major stressful life events. ● Delayed discharge from an acute care ward whilst waiting to move to a care home. ● Chronic illness and disability, particularly when effective management strategies are not in place or are inaccessible.^{12,15} ● The side-effects of specific groups of drugs and multiple medications.¹⁵ ● Separation from spouse/partner, other family members, pets and friends.¹¹ ● Bereavement following loss of spouse/partner, family members, pets and friends, where the effect on an individual bereaved person is of greater intensity and duration than the normal grieving process.¹¹ 	<p>There are local guidelines on the provision of support for older people who need to make significant decisions about their future life and care.¹³</p> <p>Specific guidance is developed to highlight health and life changes perceived by the individual as important areas for assessment.²¹</p> <p>Assessment guidance is made known to nursing staff at induction training.</p> <p>Assessment documentation demonstrates that life and health issues significant to the individual have been reviewed.²¹</p> <p>There is a range of legible and clear written information for staff, older people and carers on the causes of depression and how it can be prevented.¹⁴</p> <p>There is evidence to show that older people and their families are helped to understand and interpret information about their care and treatment.</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Nursing staff are aware that appropriate psychological, spiritual, social and physical support can lead to improvement in quality of life for the older person and their family and other supporters. ^{8,14,18}	With appropriate and timely support, older people have the continued capacity to develop and change and to feel better about life in general.	Case reviews and care documentation demonstrate that support from nursing staff contributes to positive outcomes for individuals, in terms of them achieving their personal goals. ¹⁷
Nursing staff are knowledgeable about the early signs and symptoms of depression and its causes. ^{2,15}	Prompt intervention and preventative strategies can prevent the development of depression. ¹⁴	Staff education and training programmes are in place. ² Staff records provide evidence of education and training.

Key Challenges ~

1. *Challenging the ageist perception that depression is an inevitable consequence of growing older.¹²*
2. *Recognising prevention and early detection of depression as an important care priority and taking action.*
3. *Knowing the older person as an individual and as part of a family/social community.*
4. *Recognising what defines an individual's quality of life.*
5. *Being sensitive, and intuitive to subtle changes in a person, and sharing these with colleagues.*
6. *Developing effective processes to communicate subtle and major changes, which might indicate that the older person is at risk of developing depression.*
7. *Involving family and friends and using their knowledge of the older person.⁸*

Section 2: Promoting Positive Mental Health and Wellbeing

Key Points ~

1. *Promoting care that values the older person as a unique individual.*
2. *Maintaining control in one's living environment leads to positive mental health.¹⁹*
3. *Nurses play a key role in helping older people make the transition to life in a care home or continuing care ward.¹⁹*
4. *Older people may need help to make use of positive lifelong coping methods in the face of change.*
5. *Time spent with residents and their family is seen as valuable and therapeutic.²*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>There is a care philosophy that values the person as an individual with a unique past, present and future.</p>	<p>Knowledge of the person as a unique individual contributes to that person's sense of identity and self worth. Knowledge of an individual's life history, current and future hopes and aspirations is key to person-centred care planning.</p>	<p>There is evidence within the care documentation that care is person-centred.</p>
<p>Nurses maximise an older person's ability to play a full part in any discussion about the individual's present and future plans, taking account of hearing, vision, cognitive and language ability.</p>	<p>Research demonstrates there is a high prevalence of hearing disability amongst older people.^{24,25}</p> <p>The older person who has a hearing, vision, speech or other physical or cognitive disability may be unable to communicate clearly their needs and wishes, and is therefore unable to play a full part in the decision-making process.</p> <p>Unmanaged hearing and vision disability is linked to a reduced sense of wellbeing and is associated with depression in older people.^{24,25}</p>	<p>There is access to specialist services, eg for vision and hearing, and resources to aid communication.</p> <p>There are criteria for referral to specialist services and resources.</p> <p>There is evidence within the care documentation that disabilities, which impair communication, are managed effectively.</p>
<p>Nurses promote independence and choice by enabling the older person to make their own decisions within a positive risk-taking environment²¹.</p> <p>Nurses are knowledgeable about local advocacy services, and make use of these as appropriate where they exist.</p>	<p>The older person may become disempowered if others make decisions on their behalf.¹⁶</p> <p>Control of one's environment reduces the potential for deterioration in mental health.¹⁹</p>	<p>Care plans demonstrate collaborative care/support for decisions, and demonstrate the use or offer of independent advocacy.</p> <p>Nurses provide evidence of support and encouragement (within care plans) for the older person to remain as independent as they are physically and mentally able.</p> <p>There are care philosophies, which promote independence and wellbeing.</p> <p>All residents/patients have a risk management plan that sets out rights versus risks in relation to issues that affect a person's feelings of competence and wellbeing.²¹</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Nurses in contact with the older person who is considering a move, provide support for that person prior to the move. Support might include: providing time to reflect on the move; helping the person decide what to do with belongings; requesting a final visit to the person's own home according to their wishes; ensuring that the person is involved in the choice of home; requesting a visit prior to the move.^{19,21,22}</p>	<p>Research demonstrates that the move into a care home is a major decision and the older person requires full information in order to make an informed decision.^{6,13,21}</p>	<p>A protocol/policy is developed to guide staff on helping an older person to make the transition to a care home or continuing care ward.^{18,21}</p> <p>Documentation demonstrates that information has been provided for the older person, along with opportunities to question and clarify it in order to make an informed choice.</p> <p>The older person has access to a copy of their care plan.</p>
<p>Nurses in partnership with the older person identify strategies to assist them to adapt to health and life changes.</p>	<p>People who experience loss and change may require psychosocial support with usual coping methods, personal resources and strengths, and help to develop new coping skills.^{12,18}</p> <p>Psychosocial interventions by appropriately skilled nurses are helpful and may reduce the prevalence of depression.³</p>	<p>Documentation shows evidence of planned interventions, and action to facilitate successful adaptation.</p> <p>Comments from older people on how they are feeling are documented as evidence of effective care delivery.</p>
<p>The registered nurse ensures that there are opportunities for physical, recreational and social activity relevant to the needs of patients and residents.¹⁸</p>	<p>Regular physical activity is positively associated with psychological wellbeing. Exercise is an effective intervention for preventing and treating depression and mood disorders.^{12,23}</p> <p>Meaningful social and recreational activity relieves boredom and is associated with psychological wellbeing.^{3,22}</p>	<p>Documentation shows evidence of planned activities, provided by staff or others with appropriate training, which takes into account the older person's preferences and interests.</p> <p>Evaluation of care plans shows evidence of the effectiveness of agreed interventions.</p>

Key Challenges ~

1. *Working in partnership with the older person, family and friends⁸*
2. *Forging safe and appropriate links between the care home/continuing care facility and the wider community.*

Section 3: Assessment and Care Planning

Key Points ~

1. *The older person and family contribute to assessment and care planning if this is the wish of the individual.^{19,21}*
2. *An initial screening of mental health status to include assessment of mood begins within 48 hours of admission/professional contact, and is completed within 14 days.*
3. *Other indicators of mental health change such as sleep pattern, nutritional status and ability to participate in activities of living need to be assessed over a longer period, bearing in mind that these may be affected whilst the individual adjusts to a new home.¹⁴ [Refer to Best Practice Statement on Nutrition for Physically Frail Older People, NMPDU, 2002].*
4. *Appropriate referral for specialist mental health assessment based on initial screening is essential if mental health changes are a risk to safety or affect a person's ability to cope with daily life.¹⁹*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>A registered nurse completes a formal assessment, which involves screening of mental health to include mood, on initial professional contact/admission.^{7,19}</p> <p>Repeat screening is undertaken as indicated by changes in a person's condition or at predetermined intervals.¹⁹</p>	<p>Prompt identification of older people at risk of developing depression related to health and life changes or past medical history.¹⁵</p> <p>The most effective way to reduce depression is to:</p> <p>(a) Employ preventative strategies.¹⁹ (b) Promote early detection and ensure effective treatment.⁴</p>	<p>Formal assessment includes use of a recognised screening tool, eg Geriatric Depression Scale.²⁶</p> <p>The older person's thoughts and feelings about health and life changes are documented in the assessment, and in ongoing evaluations. In instances where it is not possible to determine these, this fact is recorded.</p> <p>The older person's expectations, preferences, needs and hopes for the future are documented.¹⁷ In instances where it is not possible to determine these, this fact is recorded.²¹</p> <p>In care homes and continuing care wards there is evidence that screening is commenced on admission, repeated at least on a 3-monthly basis, and more frequently as indicated by the person's condition.¹⁹</p> <p>In all areas other than care homes and continuing care wards, there is a local policy on the use of a screening tool and frequency of review.</p> <p>Findings from screening are documented and inform subsequent clinical decision-making and collaborative planning.²¹</p> <p>Appropriate action in response to the results of the screening tool and clinical assessment are documented in the care plan.²¹</p>

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>The registered nurse involves the older person's family and other supporters in assessment, care planning and review of care if this is the wish of the individual.⁶</p> <p>The care plan includes person-centred goals, and takes account of cultural diversity, faith, and individual needs and preferences.¹⁷</p>	<p>Collaborative planning respects and values the views of the older person, family and other supporters. Care is more likely to be effective if the older person is involved in planning their own care.²²</p>	<p>Care documentation demonstrates that the older person and family and other supporters are involved in care planning, according to the wishes of the individual.²¹</p>
<p>The registered nurse draws appropriately on or makes referrals to take advantage of the specialist knowledge and skills of other interdisciplinary team members in the mental health care of the older person.^{2,21}</p>	<p>Effective mental health care requires the expertise of a range of professionals, eg general practitioner, community psychiatric nurse, consultant psychiatrist, clinical psychologist, gerontological nurse specialist, specialist counselling service.</p>	<p>Local policy specifies frequency and format of review meetings with the older person, family or other supporters, and relevant interdisciplinary team members, and there is documentary evidence that these take place.</p> <p>Local policy reflects the need for increased support when an older person is faced with health and life changes.¹⁴</p> <p>The registered nurse knows of local sources of expert advice and support where these exist, and contact with them is documented.</p> <p>Criteria for referral to specialist services are in place.</p> <p>Care documentation reflects appropriate interdisciplinary care and includes agreed goals, interventions, and review dates.¹⁷</p>

Key Challenges ~

1. *Respecting that people may wish to keep their thoughts and feelings to themselves.*
2. *Accepting that a person may be reluctant to say that they are depressed because of embarrassment and stigma associated with a diagnosis of depression.⁵*
3. *Locating sources of specialist advice in some parts of the country, for nurses who work in continuing care wards, care homes and the community.*
4. *Appreciating that what might appear to be minor issues for others can be a source of worry and distress for an individual resident.*
5. *Acknowledging that multi-professional involvement can be very threatening to the individual.*

Section 4: Education and Training

Key Points ~

1. *Evidenced-based practice cannot be achieved without investment in education and training, and opportunities to network with colleagues.⁶*
2. *Delivering care for individuals with complex needs requires practical know-how, interpersonal skills, problem solving skills and flexibility.*
3. *Training programmes include content on effective documentation skills*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Training programmes for nursing and care staff consist of:</p> <p>(a) Communication skills with the older person.</p>	<p>Older people may be reluctant to begin to talk about their feelings. Nurses need to be proactive in initiating discussion, and willing to be guided by the older person's response.¹⁰</p>	<p>Staff skills profiles demonstrate that staff are able to communicate with the older person and their family using listening skills and showing empathy.</p>
<p>(b) Factors which influence and prevent the development of depression,¹¹ including:</p> <ul style="list-style-type: none"> • Attitudes to older people. • Transition and change in later life. • Coping strategies. • Older people's access to support networks. • Sensory and cognitive changes in older age. • Relationships in care. • Empowerment and involvement of the older person and family. • Need for individualised activity. 		<p>There is evidence of ongoing training and development for all staff, and there are records of programme content.</p> <p>Training and education programmes include opportunities for regular updates.</p> <p>Staff are given time to attend updates.</p>
<p>(c) How to recognise depression^{5,12} and:</p> <ul style="list-style-type: none"> • Using screening tools. • Observing usual and altered signs and symptoms of depression specific to older people. • Being aware that other health conditions can be mistaken for depression. • Appreciating roles of specialist mental health team members and other relevant professionals. • Agreeing the criteria for referral to specialist team members. 	<p>The most effective way to reduce depression, at least in the short term, is to promote early detection and ensure adequate treatment.^{4,12}</p>	
<p>(d) The effects of institutionalisation on competence and mental health.</p>		

Key Challenges ~

- 1. Valuing education and training for the prevention of depression in older people.*
- 2. Setting priorities for training programmes to support practice development.*
- 3. Designing accessible training packages for all staff that value everyone's contribution to care.*
- 4. Developing strategies for translating knowledge into practice.*

Appendix 1

Sources of Evidence

The level of evidence according to the SIGN grading system is shown in square brackets at the end of each reference.

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Appendix 2

Scottish Gerontological Link Nurse Network Members

Margaret Anderson	Specialist Nurse Practitioner	Mansion House Unit	Glasgow
Linda Bastianiello	Ward Leader	Ashludie Hospital	Monifieth
Margaret Bradley	Staff Nurse	Lightburn Hospital	Glasgow
Andrea Brown	Charge Nurse	Cameron Hospital	Leven
Linda Bruce	Clinical Care Manager	Middleton Hall Care Centre	West Lothian
Sandra Cameron	Senior Nurse	St John's Hospital	Livingston
Linda Campbell	Clinical Ward Manager	Raigmore House	Inverness
Duncan Clarkson	Director of Nursing	Whim Hall Nursing Home	Peebleshire
Pauline Cranston	Staff Nurse	Blar Buidhe Nursing Home	Stornoway
Mary Creed	Assistant Matron	Pittendreich Nursing Home	Edinburgh
Jean Donaldson	Care Home Liaison Nurse	Strathclyde Hospital	Motherwell
Muriel Douglas	Senior Sister	Borders General Hospital	Roxburghshire
Michelle Findlay	Staff nurse	Balfour Hospital	Orkney
Morag Francis	Sister	Braeside House Nursing Home for the Elderly Blind	Edinburgh
Sue Gardiner	Clinical Nurse Practitioner	Royal Victoria Hospital	Edinburgh
Amanda Garrity	Senior Sister	Braemount Nursing Home	Paisley
Morag Glendye	Sister	Kirkcudbright Community Hospital	Kirkcudbright
Fiona Gordon	Clinical Nurse Manager	Bannockburn Hospital	Bannockburn
Helen Grant	Matron/Manager	Annfield House	Stirling
Nancy Hamilton	Compliance & Monitoring Officer	Salvation Army	Greenock
Liz Hotchkiss	Deputy Manager	Eastwood Court Nursing Home	East Renfrewshire
Jean Howieson	Ward Sister	Kirklands Hospital	Bothwell
Shona Hunter	Clinical Nurse Manager	Whim Hall Nursing Home	Borders
Mary Kelly	Matron	Manor Parc Nursing Home	Glasgow
Mary Macgee	Senior General Manager & Divisional Nurse	Ashbourne Homes	Glasgow
Fiona Mann	Matron/Manager	Buchanan Lodge	Bearsden
Freda Matheson	Staff Nurse	Isle View Nursing Home	Wester Ross

Matilda McCrimmon	Deputy Sister	Vale of Leven Hospital	Alexandria
Margaret McLeish	Sister	Lightburn Hospital	Glasgow
Louise Millar	Deputy Manager	Westminster South Grange Nursing Home	Dundee
Donna Morrison	Specialist Practitioner	Royal Dundee Liff Hospital	Dundee
Linda Mounsey	Assistant to Chief Executive	St Margaret's Hospice	Clydebank
Marea Mulholland	Staff Nurse	Southern General Hospital	Glasgow
Mae Munro	Manager	Culloden Court	Inverness
Tom Norton	Nursing Home Manager	Woodlands Nursing Home	West Lothian
Nanette Paterson	Registered Nurse/Matron	Crofthead House Nursing Home	West Lothian
Lyndsey Redden	Staff Nurse	Moorburn Manor	Largs
Helen Reid	Sister	Mearns Kirk Hospital	Glasgow
Nancy Reid	Practice Development Nurse	Ravensraig Hospital	Greenock
Lindsay Ross	Specialist Practitioner	Royal Victoria Hospital	Dundee
Pauline Sewell	Staff Nurse	Ainslie Manor Nursing Home	Girvan
Lorna Stones	Charge Nurse	Queen Margaret Hospital	Dunfermline
Ria Tocher	Clinical Development Nurse	Corstorphine Hospital	Edinburgh
Christine Tonge	Health Visitor for the Elderly	Health Centre	Shetland
Anne Turnbull	Senior Sister	Dumfries & Galloway Royal Infirmary	Dumfries



Appendix 3

Definition and Principles of Gerontological Nursing

Gerontological nursing contributes to and often leads the interdisciplinary and multi-agency care of older people. It may be practiced in a variety of settings, although it is most likely to be developed within services dedicated to the care of older people.

It is a person-centred approach to promoting healthy ageing and the achievement of wellbeing, enabling the person and their carers to adapt to health and life changes and to face ongoing health challenges.

To achieve this, in-depth gerontological nursing knowledge and skills are required alongside a commitment to an explicit value base. The virtual practice development community of link nurses has developed a set of principles, which reflects its beliefs about gerontological nursing:

1. Commitment to person-centred care

Understanding and acknowledging the needs and wishes of the older person and ensuring that these underpin the planning and delivery of care. Promoting continuity of care that values the older person's unique past, present and future individuality and recognising and respecting the person's role and contribution to family and wider society.

2. Commitment to an enabling model of care

Recognising the uniqueness of each older person, and building on positive lifelong coping skills and strategies. Negotiating and reviewing care goals in partnership with the older person and family, according to the individual's needs and wishes.

3. Promotion of an enabling environment

Promoting positive staff attitudes together with a supportive physical and organisational environment in order to create an enabling living, or care environment that conveys a sense of hope and achievement for the older person.

4. Respect for a person's rights and choice

Respecting and promoting the rights of each older person as a consenting adult to make independent choices and care decisions, according to the person's wishes, and recognising when it is necessary to draw on patient advocacy services.

5. Promoting dignity

Promoting dignity in day to day care to include consideration for the older person's privacy and confidentiality.

6. Establishing equity of access

Acting as champion and striving to secure on behalf of all older people the same access to services as other age groups.

7. Maximising therapeutic interventions

Developing attitudes, knowledge, and skills in order to turn a caring event into a therapeutic opportunity for the older person and, where appropriate, their family.

8. Commitment to developing innovative practice

Adopting strategies to promote evidence based gerontological nursing practice, and advancing knowledge, skills and competencies of staff through continued education and research.

9. Commitment to an explicit and shared set of values

Developing an agreed care philosophy that seeks to maintain the uniqueness of the older person, reflecting their needs and identifying the standards of care which they can expect.

10. Commitment to interdisciplinary working and partnership

Working as part of a team of experts who recognise, seek out and respect each other's contribution to the care of the older person. Directing the collective effort towards the realisation of goals negotiated with the older person and their family, according to their needs and wishes.

Appendix 4

SIGN Grading System

Levels of Evidence

- 1++ High quality meta analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias.
- 1+ Well conducted meta analyses, systematic reviews of RCTs, or RCTs with a low risk of bias.
- 1 - Meta analyses, systematic reviews of RCTs, or RCTs with a high risk of bias.
-
- 2++ High quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding, bias or chance, and a high probability that the relationship is causal.
- 2+ Well conducted case-control or cohort studies with a low risk of confounding, bias or chance, and a moderate probability that the relationship is causal.
- 2 - Case-control or cohort studies with a high risk of confounding, bias or chance, and a significant risk that the relationship is not causal.
-
- 3 Non-analytic studies, eg case reports, case series.
-
- 4 Expert opinion.

Grades of Recommendation

- A** At least one meta analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or
A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.
- B** A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 1++ or 1+.
- C** A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or
Extrapolated evidence from studies rated as 2++.
- D** Evidence level 3 or 4; or
Extrapolated evidence from studies rated as 2+.



Personal Notes/Local Contacts

Personal Notes/Local Contacts



Personal Notes/Local Contacts

Our Commitment

Our work will be undertaken in line with the following values:

- **patient and public focus**
 - ~ promoting a patient-focused NHS that is responsive to the views of the public
- **independence**
 - ~ reaching our own conclusions and communicating what we find
- **partnership**
 - ~ involving patients, carers and the public in all parts of our work
 - ~ working with and supporting NHS staff in improving quality
 - ~ collaborating with other organisations such as public bodies, voluntary organisations and manufacturers to avoid duplication of effort
- **evidence-based**
 - ~ basing conclusions and recommendations on the best evidence available
- **openness and transparency**
 - ~ promoting understanding of our work
 - ~ explaining the rationale for our recommendations and conclusions
 - ~ communicating in language and formats that are easily accessible
- **quality assurance**
 - ~ aiming to focus our work on areas where significant improvements can be made
 - ~ ensuring that our work is subject to internal and external quality assurance and evaluation
- **professionalism**
 - ~ promoting excellence individually and as teams and ensuring value for money in the use of public resources (human and financial)
- **sensitivity**
 - ~ recognising the needs, opinions and beliefs of individuals and organisations and respecting and encouraging diversity

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- Electronic
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