Local practices influence hospital discharge for patients with dementia

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Introduction

The acute care of people with dementia in hospital is complex, with prolonged length of stay, increased risk of delirium and a strong association with entry into residential aged care (RAC) after discharge. The Hospital Dementia Services (HDS) Project is an innovative project that explores how hospital based services influence outcomes for people with dementia who were admitted to hospital in New South Wales (NSW), Australia in 2006-07.

Aim

This presentation describes how local hospital-based practices influence the pathways of patients with dementia ***from*** NSW public hospitals. To illustrate the influence of local practices, the description focuses on hospitals with general services (i.e. hospitals without acute aged care beds), which makes up 79% of the total number of hospitals in our study.

Research questions:

1. What services and expertise play a role in discharge of patients with dementia from **hospitals without aged care wards**?
2. What local practices influence discharge for patients with dementia from **hospitals without aged care wards**?

Data sources

Data used in this presentation were sourced from the HDS survey and site visits.

2010 survey of NSW hospitals (hospitals with general services=156; Response rate=78%) reporting on 2006-7 services with:

- 12% major cities
- 44% inner regional
- 35% outer regional
- 9% remote/very remote.

2010 site visit of purposefully selected hospitals from metropolitan, regional and remote areas, with general and specialist services and diverse cultural geographies including interviews with individuals and groups and escorted tours of facilities. Of the 19 visited sites, 13 hospitals did not have an aged care service, among which:

- 15% major cities
- 62% inner regional
- 23% outer regional
- 0% remote/very remote.

Analysis

- Descriptive statistics of survey data.
- Thematic analysis of researcher notes from site visits.

Abbreviations

AARCS: Acute to Aged Related Care Service

ACAT: Aged Care Assessment Team

ASET: Aged-care Services in Emergency Team

BPSD: Behavioural and psychological symptoms of dementia

CACP: Community Aged Care Package

ComPacks: a case-managed package of care for up to 6 weeks after discharge from hospital

Dementia CNC: Dementia Clinical Nurse Consultant

EACH: Extended Aged Care at Home

EACH-D: Extended Aged Care at Home Dementia

ED: Emergency Department

GP: General Practitioner

HACC: Home and Community Care

TACP: Transition Aged Care Program

Results: Services and Expertise in hospitals without aged care wards

Skilled personnel in key positions (eg ASET, AARCS, Discharge Planners, visiting geriatricians):

- 40% had access to medical specialists such as Geriatricians or Psychogeriatricians in 06-07
- 21% had access to Dementia CNCs or other dementia interface positions in 06-07
- 12% of Hospital Emergency Departments had dedicated personnel with dementia expertise (usually ASET) in 06-07.

People in positions such as ASET, AARCS, Aged Care CNCs and Dementia CNCs play an important role in:

- Identifying delirium and dementia in patients, enhancing appropriate clinical care in hospital, and advocating for the needs of people with dementia
- Managing relationship between hospital and community-based services and organising post-hospital care.

Post acute care:

- 20% of hospitals had access to TACP in 06-07
- TACP were not heavily used for people with dementia because of ability to comply with therapeutic goals
- 23% had access to other time limited community care (eg ComPacks) in 06-07
- ComPacks highly used and valued but not always suitable for patients with dementia

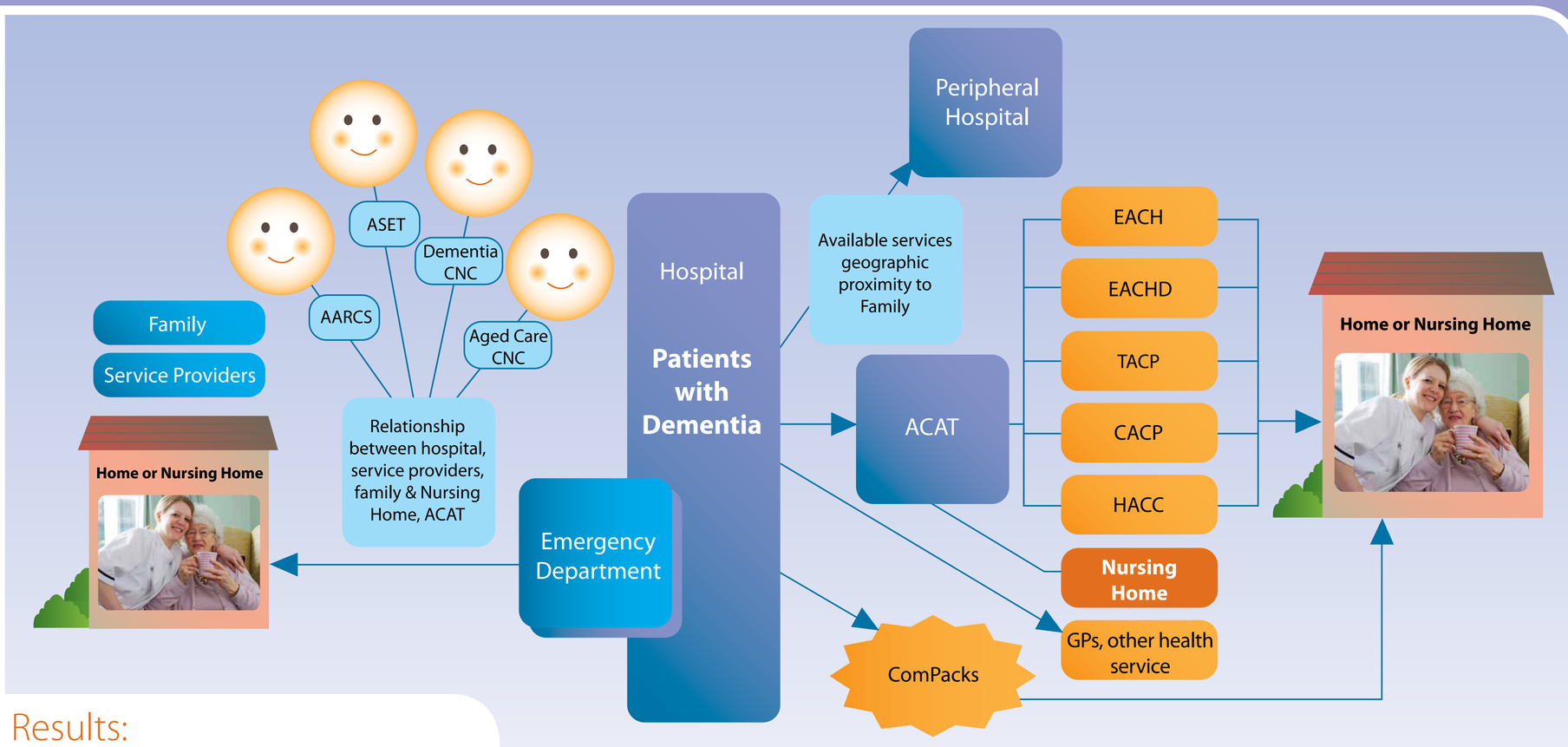
- Use of peripheral hospitals especially when waiting for placements and/or returning patients closer to family
- Not all peripheral hospitals have adequate or appropriate services to care for patients with dementia.

Access to ACAT Assessments:

- 98% had access to ACAT in 06-07
- In some areas, long waiting list for ACAT assessment, sometimes different interpretation of acuity and needs.

Long term care in residential and community services:

- 98% had access to HACC in 06-07
- 89% had access to CACP
- 58% had access to EACH
- 35% had access to EACH-D
- Variable availability of long term care places especially for patients with BPSD and young patients with early on-set dementia.



Findings: Good discharge starts from the beginning

Results: Local Practices/ Processes in hospitals without aged care wards

- Multi-disciplinary meetings involving all relevant staff facilitated discharge planning which took account of patient and family carer needs in the context of hospital bed management pressures.
- Flow of information and documentation underpins good communication between all relevant services within the hospital and in the community. Examples include:
  - » Patient assessment forms from ED to wards and appropriate clinicians
  - » Yellow envelops with information between hospitals and nursing home and community services providers
  - » Green card for GP follow-up
  - » Colour coding of "Aged Care" information on patients' notes in hospital.
- Relationship building and good communication ensured that existing services were maximised for patient benefit. Examples of formal practice include:
  - » Aged care forums involving staff from acute and community sectors
  - » Meetings with families
  - » Clinical care trials in nursing homes to support post-hospital care.

Conclusions

1. Many of the general hospitals had limited access to aged care and dementia specific services.
2. Presence of skilled staff plus good communication/ relationship between staff in hospital and community improved operation of limited services.
3. While informants mostly suggested that identification of dementia and delirium had improved, it remains an area of concern – affecting patient care – particularly the misidentification of delirium as dementia.
4. Short-term post-hospital discharge programs were suitable for only small number of patients with dementia – there was a gap in service provision.
5. Discharge of persons with BPSD was often delayed due to difficulty in obtaining suitable longer-term care services.
6. ACAT performed critical roles in discharge process – resource constraints frequently had impact on waiting times for assessments.
7. Key skilled staff improved dementia awareness among hospital staff which supported appropriate care and discharge.
8. Many clinical staff had strong client focus.

Implications

- Funding of key positions, including discharge planner, with aged care and dementia expertise is vital for effective local discharge practice.
- Need for more dementia-specific post-hospital discharge services.
- Integration of services is an important factor influencing the discharge process.
- Development of high level policy should be informed by local context and expertise in relation to dementia services.

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HDS PROJECT
Hospital Dementia Services