Local practices influence hospital discharge for patients with dementia

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 dementia from 6 weeks after discharge from hospital.

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 HDS survey and site visits. 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
- 44% inner regional
- 35% outer regional
- 9% remote/very remote.

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

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?

Results: Services and Expertise in hospitals without aged care wards

-**Skilled personnel in key positions**
- 40% had access to medical specialists such as Geriatricians or Psychologists.
- 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.

-**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 care 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 envelopes with information between hospitals and nursing home and community services providers.
  - Green card for GP follow-up.
  - Colour coding of ‘Aged Care’ information on patient’s 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
- 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 O.
- Variable availability of long term care places especially for patients with BPSD and young patients with early on-set dementia.

Implications
- Funding of key positions, including discharge planner, with aged care and dementia expertise is vital for effective local discharge practice.

Acknowledgments
We sincerely thank all hospitals that participated in the survey, hospitals that hosted our site visits and staff who spent time with us during site visit interviews. Our study would not be possible without them.

Abbreviations
AARCS: Aged to Related Care Service
ACAT: Aged Care Assessment Team
ASET: Aged Care Assessment 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
ECH: Extended Aged Care at Home
ECHD: Extended Aged Care at Home Dementia
ED: Emergency Department
GP: General Practitioner
HACC: Home and Community Care
TACP: Transition Aged Care Program

Results: Use of peripheral hospitals especially when waiting for placements and/or returning patients closer to family.

Access to ACAT Assessments:
- 98% had access to ACAT in 06-07.

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 O.

Variable availability of long term care places especially for patients with BPSD and young patients with early on-set dementia.

Implications
- Funding of key positions, including discharge planner, with aged care and dementia expertise is vital for effective local discharge practice.

Acknowledgments
We sincerely thank all hospitals that participated in the survey, hospitals that hosted our site visits and staff who spent time with us during site visit interviews. Our study would not be possible without them.