Australian Government
Australian Institute of Health and Welfare

Report **Profile**

Movement between hospital and residential aged care 2008–09

There is considerable movement of older Australians between hospital and residential aged care (RAC). The report *Movement between hospital and residential aged care 2008–09* updates and extends a 2001–02 study on movement from hospital into RAC by people aged 65 and over. Importantly, the use of hospitals by people already living in residential care is examined for the first time.

The study focuses on people aged 65 and over by 1 July 2008 and their hospital episodes ending in 2008–09 that included at least 1 night in hospital. Transfers between hospital and RAC (for either permanent or respite care) or the Transition Care Program (TCP) were identified by linking national 2008–09 hospital and RAC service use data (see Study scope below). Deaths of RAC clients outside hospital were identified through linkage to the National Death Index.

Fast facts

For people aged 65 and over, across Australia in 2008–09:

- There were 1.1 million hospital discharges after at least 1 night in hospital.
- 9% of hospitalisations were for people living permanently in RAC.
- 0.6% of hospitalisations were for people coming either from residential respite care or from transition care.
- In 83% of hospital discharges, people returned to live in the community.
- In 8% of hospital discharges, people returned to their home in RAC.
- Just over 3% of hospitalisations ended with the patient being newly admitted into residential care, mostly for permanent care.
- 5% of hospitalisations ended with the patient's death; nearly one-fifth of these people had come from permanent RAC.
- There were just over 120,000 admissions into RAC nationally, including transfers between RAC facilities.
- One-third of admissions into RAC were from hospital; two-thirds of these admissions were for permanent care.

Reasons for entering hospital

Patients admitted from residential care tended to have different reasons for entering hospital than others (Figure 1). For example, respiratory conditions (17%) were the most common reason for the admission of permanent aged care residents while circulatory conditions (19%) were most common for people admitted from the community. Falls were a much more common cause of admission for aged care residents (10% versus 5%).

Although not a common diagnosis as cause of admission (Figure 1), dementia was reported as affecting hospital care in a high proportion of hospitalisations for people coming from RAC: around one-quarter compared with 4% of admissions for people living in the community (Figure 2). This is no surprise as dementia is often a leading factor in admission into RAC. Also, the relatively high report rates of *staphylococcus aureus* (golden staph) and pressure ulcers show that people coming from RAC comprise a frail group that is at high risk of getting these conditions.

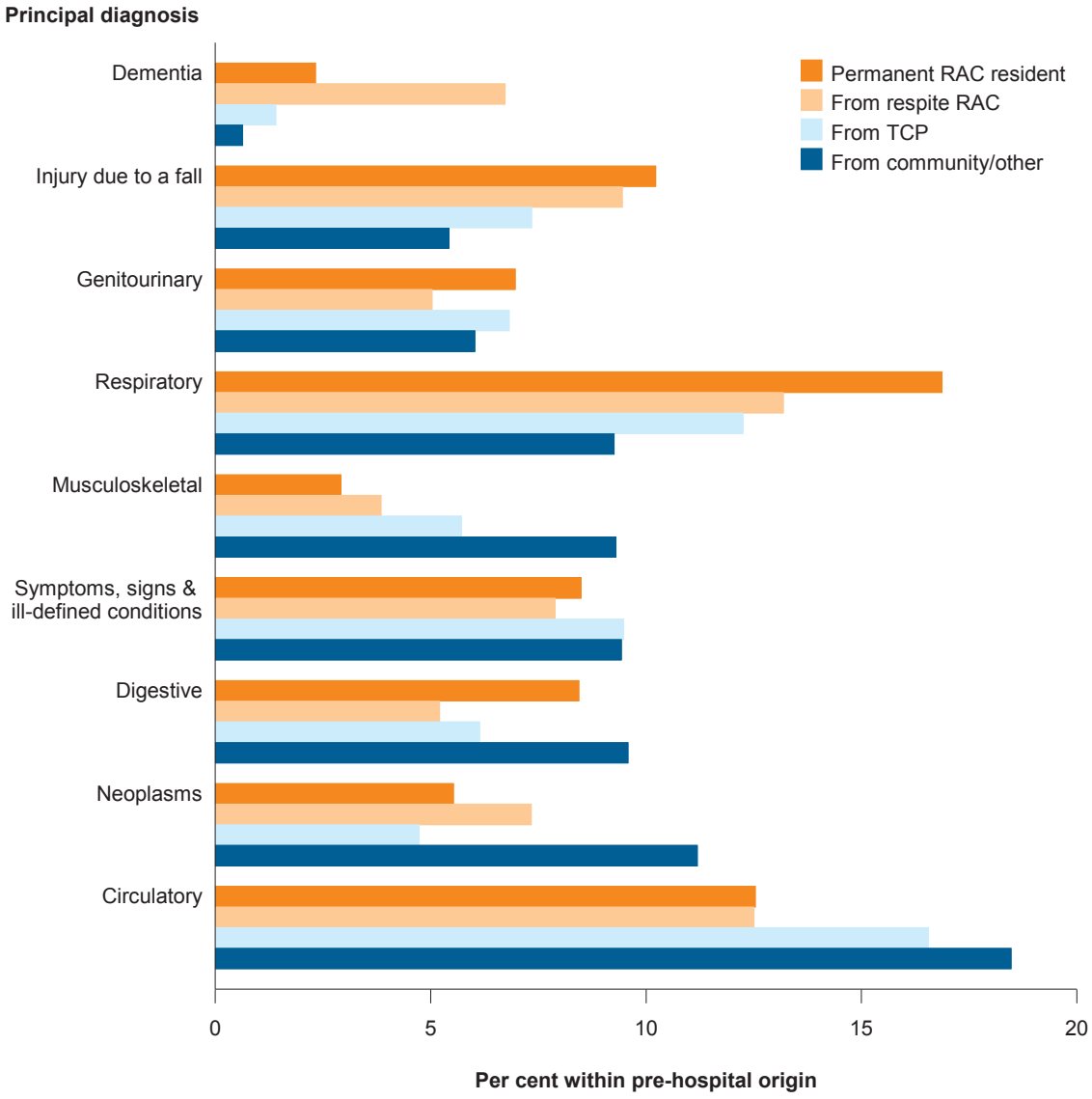

Figure 1: Selected principal diagnoses responsible for admission into hospital, by pre-hospital origin, separations in 2008–09 (standardised per cent)

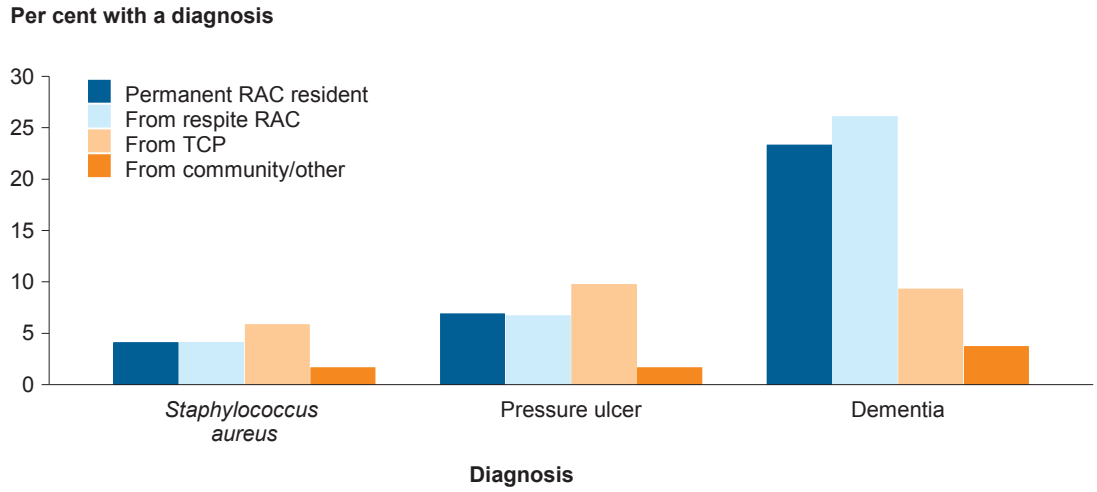

Figure 2: Selected diagnoses reported as any diagnosis in the hospital episode, by pre-hospital origin, separations in 2008–09 (standardised per cent)

Movement from hospital into residential aged care

People were more likely to be admitted into residential care than return to the community after hospitalisation if they: had a longer stay in hospital; were diagnosed with dementia or stroke; were of an older age; had an unplanned admission; or were in palliative care before discharge. The movement from hospital into RAC was also affected by the state or territory where the hospital was located. Having at least one of a group of comorbid conditions (that is, conditions occurring simultaneously with the principal diagnosis) also tended to increase the likelihood of entering care. Lower levels of English proficiency were associated with a reduced tendency to enter residential care.

Geographic effects were seen to predict admission into residential care and whether that care was permanent, with some jurisdictions having greater movement into residential care than others, and with people living in a major city before hospitalisation being more likely than other patients to be admitted into permanent rather than respite care. This indicates that variation in jurisdictional and regional aged care service provision and/or practices may be influencing outcomes.

Time in hospital

If a patient transferred between hospitals or received more than one care type while in hospital, their hospital stay would have been reported as a number of episodes. Overall, 15% of hospital discharges involved a multi-episode stay. However, more than half (55%) of people who were discharged to permanent RAC as a new admission left after a multi-episode stay. By comparison, almost 90% of people discharged back to their usual residence had a single-episode stay. Episodes that were the last of several in a stay tended to be longer than single-episode stays (mean of 16.6 days compared with 6.1 days).

People transitioning from the community into permanent residential care via hospital had the longest stays in hospital, with single-episode stays (that is, no hospital transfers) averaging 28.0 days compared with the overall average of 6.1 days. People who returned to their usual residence on discharge tended to have the shortest stays. Death in hospital was generally preceded by a stay of moderate length (mean of 12 days for a single-episode stay).

Use of respite care after a stay in hospital

The patterns of service use after people were admitted into residential respite care from hospital indicated that respite care was playing a dual role in 2008–09: as post-hospital care before returning home and as a stepping stone into permanent care (Figure 3). One-third of people admitted to respite care from hospital were discharged to the community within 12 weeks. A further 15% were discharged back to hospital within 12 weeks of their admission. Of the remainder—about one-half of those admitted to respite care from hospital—three-quarters were in permanent care at the 12-week point, and one-fifth had died in the care facility (9% of all people admitted to respite care from hospital).

Among people admitted from hospital into permanent RAC, the overwhelming majority (93%) did not leave RAC within 12 weeks of admission; one-fifth of these died in the RAC facility. The majority of those who left RAC within 12 weeks of admission were discharged back into hospital.

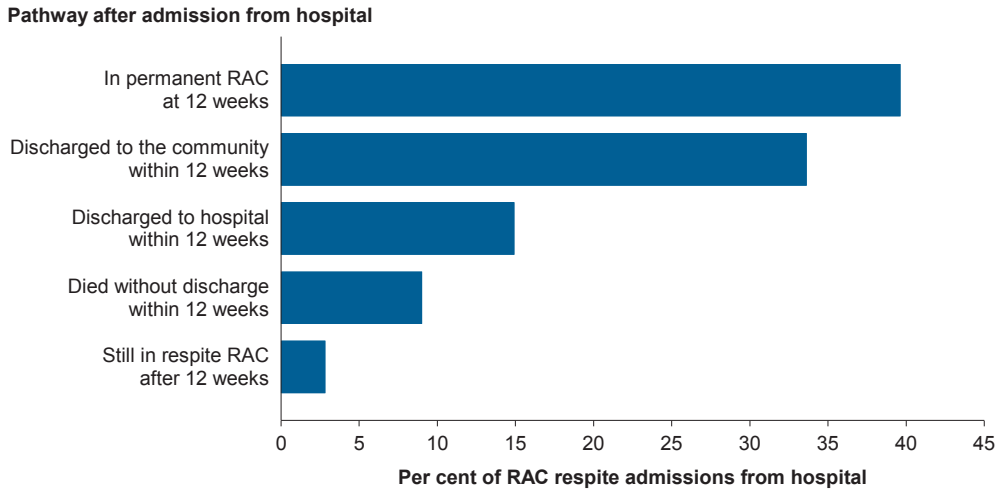

Figure 3: Pathway in the 12 weeks after admission into RAC from hospital, first RAC respite admission 2008–09

Study scope

- The hospital episode included at least 1 night in hospital and ended in 2008–09.
- The hospital patient or RAC client was aged 65 and over by 1 July 2008.
- For analysis of movement into hospital, hospital episodes must have started with admission from outside the hospital sector.
- For analysis of movement from hospital, hospital episodes must have ended with discharge from the hospital sector.
- A person's admission into RAC was assumed to be 'from hospital' if it was within 7 days of hospital discharge.
- Transfers within RAC included both same-day and next-day moves.

For more information

The full report can be downloaded free of charge from <www.aihw.gov.au>.

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