Decisions affecting discharge from hospitals directly to care homes

Key points

1 Care home admission directly after an acute hospital stay is common, although UK health policy advises against it.

2 The decision to discharge a hospital patient to a care home is influenced by many factors, including family request, dementia and mobility.

3 Health professionals need to improve the documentation of significant conversations and evidence of person-centred care.

4 Patients must be involved in the discussions about their future place of care, even if they lack mental capacity to make decisions.

5 Delirium is serious but potentially preventable and treatable, so hospital staff must be trained to recognise it and take account of it during discharge decision making.

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Abstract
Admission to care homes following acute hospital admission is common, despite being contrary to UK health policy. Care home admission from hospital is also a care trajectory that is under-researched and poorly understood. A retrospective cohort study reviewed the case notes of 100 people who had experienced this transition, what happened during their hospital stay, and what led to the life-changing decision to discharge them to a care home. Only 37% of individuals were documented as having been involved in the decision-making process. This article describes the study methods, highlights some salient results, and makes recommendations for practice.

Citation
In the context of greater health and social care integration, and of growing pressures in both sectors, we need to understand more about this trajectory so we can better support the individuals involved. Indeed, in Scotland, one of the proposed markers of health and social care integration is new care home admissions from hospital (Scottish Government, 2015).

Although care home admission from an inpatient setting is a common occurrence, there is little research in this area. Practitioners have a wealth of experience and perspectives to share, but these have not been adequately captured, and the views of patients and families have generally not been represented in the literature.

Our research team sought to:

- Describe the people who are admitted to care homes from hospital;
- Evaluate the assessment process and care received during their inpatient stay, in order to identify good practice and areas for improvement.

This article presents elements of our findings, which have been reported in full elsewhere (Harrison et al, 2017a), reflecting the implications for nurses and multi-disciplinary teams.

Method

Using admission and discharge codes, the research nurse identified 100 adult patients who had been admitted from home to a large Scottish university teaching hospital and discharged directly to a care home at the end of their hospital stay. Included patients could have been admitted to any department of the hospital and could have been transferred between departments for rehabilitation before discharge.

The research nurse obtained and reviewed ward-based case notes, and extracted data using a pre-designed form. Case notes included all nursing, medical and allied health professional documentation, plus that added by social workers and other hospital specialists.

The following data was extracted:

- Pre-admission health status – medical history, medications, mobility and continence;
- Social circumstances – living arrangements, marital status and whether patient was receiving formal, informal or voluntary sector care;
- Anticipatory care planning – power of attorney, advance statements and incapacity certification;
- Hospital admission – admitting specialty, presenting complaints, length of stay and transfers;
- Inpatient care – falls, cognitive assessments, mental health support, delirium, behavioural disturbance, and occupational therapy, physiotherapy and social work involvement;
- Discharge planning – when were discharge planning discussions initiated? When was care home admission decided? Who was involved in the decision? What were the reasons for that?

There was additional space for free-text notes about aspects the research nurse considered important. As the intention was to establish a clear picture of events during admission, cases with gaps in documentation of more than one week’s duration were excluded. To ensure consistency of approach, a second researcher examined a sample of case notes, comparing their findings with those of the research nurse.

The sample was non-consecutive, as 96 sets of notes had missing data and 44 patients had been selected for the study due to coding errors and were therefore ineligible for inclusion. This meant that, to obtain a sample of 100, 273 case notes were initially reviewed.

Key findings

Table 1 summarises key descriptors of the study population at the time of admission. All patients had been admitted as an emergency, predominantly under the care of the medical team (88%). The median length of stay was 78.5 days (range 14-231 days).

Transfers of care within the hospital were common: 50% of patients were transferred from an acute to a non-acute setting for rehabilitation and/or complex discharge planning, 45% were boarded out of their parent ward during their admission and 31% were moved three times or more. The most common presenting complaints were falls, confusion and sepsis.

Just over half of the patients in the study (51%) experienced at least one episode of delirium during their hospital stay, but a third of these had not been identified as such by the clinical team. Ninety-two per cent of patients in the study received input from the physiotherapy team and 53% were assessed by an occupational therapist; 55% were in an acute setting when the decision to discharge them to a care home was made. The decision was made at a median 26 days after admission, although this ranged from zero to 249 days.

The most common reasons for the decision were family request, dementia and mobility limitations.

Fig 1 summarises the striking difference between the documented involvement of individual patients (involved in 37% of cases) and of families (involved in 90% of cases). As defined by the researchers, ‘involvement’ was not limited to participation in making the decision, but also included discussing place of care preferences with members of the MDT. Whether or not patients were involved was not associated with a dementia diagnosis or completion of section 47 of the Adults with Incapacity (Scotland) Act 2000 (which regards medical treatment).

At the time of discharge, only 28% of patients were documented as being fully continent, compared with 62% on admission. Among the 89 patients for which we had complete continence data on

| Table 1. Key descriptors of study population on admission |
|---------------------------------|-----|
| Descriptor│Result |
|---------------------------------|-----|
| Median age, yrs (range)         │84 (61-101) |
| Female, %                       │62   |
| Widowed, %                      │52   |
| Living alone, %                 │67   |
| Housebound pre-admission, %     │16   |
| Pre-admission package of care (state-provided), % │73   |
| Family support, %               │92   |
| Walking frame to mobilise, %    │35   |
| Fully continent, %              │62   |
| Cognitive impairment (dementia, delirium or cognitive impairment detected by cognitive testing), % │95   |
| Previous recurrent hospital admissions, % │37   |
| Concerns raised about ability to cope at home, % │42   |
discharge, 26% remained fully continent throughout their hospital stay, 2% regained continence during their hospital stay, 36% were incontinent throughout their hospital stay, and 36% became newly incontinent during their hospital stay.

**Discussion**

We believe this is the first study conducted in the UK of patients newly admitted to a care home following a hospital stay. Some aspects are in keeping with what may be expected: patients were mostly older women, very often with cognitive impairment, predominantly admitted under the medical team, and many were receiving social care. However, the study reveals that:

- Some patients had long hospital stays;
- Many experienced multiple transfers of care;
- Only a minority (37%) were involved in this life-changing decision.

It is not well understood why people are discharged from hospital to a care home. Our data indicates that family request, dementia and mobility limitations are important factors, but we know the situation is much more complex.

A systematic literature review identified that older women with dementia and functional impairment are the group most likely to require care home admission at discharge (Harrison et al, 2017b). However, these factors aren’t particularly helpful in working out which patients in hospital will go into a care home as they are so common, and important factors such as the availability and cost of social care were not taken into account.

Discharge to a care home from an inpatient hospital setting occurs frequently, and more work is needed to understand:

- How this differs from care home admissions from community settings;
- Why the need arises – is it related to a breakdown of care at home or an acute deterioration of chronic disease? Or is care home admission being used to signal to the individual and family that increased care is now required?
- How inpatient models of care affect the need for care home admission.

The National Institute for Health and Care Excellence (2015) recommends that health professionals:

> “Ensure that people do not have to make decisions about long-term residential or nursing care while they are in a crisis.”

How do we ensure this applies to hospital inpatients, especially at a time when there are significant pressures on hospital beds and social care in the community? Services such as comprehensive geriatric assessments (Ellis et al, 2011) and non-acute intermediate care (Hutchison et al, 2011) are likely to help avoid or delay the need for care home admission. However, the provision of, and access to, these services differ greatly across the UK. Can we amass the evidence needed to make the case for investing in those services? Perhaps more controversially, are there some people who should be admitted directly to a care home following a hospital stay? And if so, how do we counter the current policy narrative and change the recommended care trajectories?

**Recommendations for practice**

**Patients with cognitive impairment**

We need to consider how to involve adults with cognitive impairment in decision making. There is a distinction, which may be overlooked in clinical practice, between the mental capacity to make decisions about one’s future care and the ability to be involved in the decision-making process.

Many in our cohort may not have been considered to have the mental capacity to decide where they wanted to live; however, all legislation on mental capacity, as well as the Charter of Rights for People with Dementia and their Carers in Scotland (Cross-Party Group in the Scottish Parliament on Alzheimer’s, 2009), makes it clear that having dementia or impaired cognition does not mean that the person should be excluded from decision making.

We encourage staff to work with families to identify how best to involve patients in discussions and decision making to ensure their views are taken into account.

**Significant conversations**

We need to improve the documentation of significant conversations that evidence person-centred care. Opportunistic conversations happening outside formal ward rounds – for example, during care – need to be captured in patient records. Ensuring that documentation evidences the care provided is important, both for recording what has been done and for enabling colleagues to learn from it.

Following health and social care integration, plans are in place in Scotland to share documentation between healthcare and social work teams: this will improve communication and ensure all are fully informed of documented conversations.

**Electronic records**

Missing data in health records is exacerbated by the use of paper-based records, and we welcome the increasing use of electronic case notes to counter this issue. Electronic systems should also improve the sharing of information between health and social care professionals.

**Clinical coding**

We need to improve the accuracy of clinical coding – in particular when recording where a person is admitted from and/or discharged to. Coding data entered by health professionals is used to generate statistics that allow us to compare hospitals’ performance. Variation in the accuracy and completion of clinical coding – a recognised problem – has significant negative...
implications for hospitals and wider society’s understanding of the population’s health and care needs (Medford, 2013).

Delirium
Experiencing delirium during an inpatient stay is known to increase the likelihood of death, dementia and the need for long-term care (Witlox et al, 2010). In keeping with previous research, we found that delirium was often unrecognised by the clinical team and therefore not fully evaluated and managed.

We need to improve the identification of delirium by educating and empowering staff so they are confident in recognising it for what it is: a serious but potentially preventable, treatable and transient condition. Only then will staff be able to engage in prevention activities known to reduce the incidence of delirium by a third (Sid-diqi et al, 2016), and ensure patients’ cognitive and physical function return to baseline before long-term decisions are made. This is especially important given that delirium can persist for months and yet still potentially resolve (Cole et al, 2009).

Some adults need care that cannot easily be provided in the community setting
patients’ social work records, which are stored separately on an electronic system. The most important limitation, however, is that we relied on what had been documented. While this allowed us to view practice in the same way as regulators and internal evaluation bodies, there may have been other undocumented interactions and conversations that could have enriched our understanding of this complex topic.

Future research
The findings of this study have stimulated valuable discussion among clinical and academic audiences. However, mindful of the limitations of using case-note review – in particular to capture patient experiences – we know this was very much a first step. We plan to conduct an in-depth qualitative interview study with patients, families or other significant persons, and members of the MDT; these interviews will be supplemented by a review of ward-based case notes and social care records to help us understand the extent to which documentation captures care processes.

Our hope is that listening to those involved will help us define what constitutes best practice in this area and provide guidance for individuals, families and hospital teams when making these life-changing decisions. NT

Hospital-acquired incontinence
We had not anticipated the findings about incontinence, and they require further investigation locally. There may be issues with recording and evaluating continence at baseline, and continence may deteriorate as a consequence of disease, but the apparent decrease during hospital stay in the number of fully continent patients in our cohort hints at hospital-related harm.

Incontinence is a predictor of the need for care home admission in community-dwelling adults (Luppa et al, 2010) and is likely to be important in hospital decision making. While the study was not designed to establish all the reasons for discharge to a care home, we know from experience that incontinence, particularly overnight, is often raised as a concern.

Limitations
While we recognise the value of our findings, we also acknowledge their limitations. Our data is from a single centre and may, therefore, be difficult to generalise. We did not compare between patients admitted to a care home and patients who returned home. We were not able to access

References
National Institute for Health and Care Excellence (2015) Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs. nice.org.uk/eq7