



Knowledge base

Hospital Discharge: A Descriptive Study of the Patient Journey for Frail Older People with Complex Needs

Fraser Mitchell

Team Manager, Social Work Service, Fife Council, UK

Mhairi Gilmour

Research & Development Officer, Department of Public Health, NHS Fife, UK

Gordon McLaren

Consultant in Public Health Medicine, NHS Fife, UK

Contact details: Fraser.Mitchell@fife.gov.uk

ABSTRACT

This paper reports on a descriptive study using locally available health and social care data relating to the patient journey of a cohort of frail, older people with complex health and social care needs. The study identifies contact with social care services and some health services prior to hospital admission, charts the patient journey in hospital, and provides information on discharge destinations. The findings have implications for the discharge planning process and the improvement of community care services, including intermediate care.

KEY WORDS

hospital discharge; older people; frailty; health inequalities; intermediate care

Introduction

Health and social care services face increasing challenges as the population ages. Successful discharge of frail older people from hospital requires effective partnership working between health and social care agencies (Henwood, 2006).

This paper describes a partnership approach to service evaluation, with a focus on 30 frail older people with complex needs admitted from the community to hospital as an emergency. The information gathered is being used to support the improvement of community

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services to shift the balance of care towards more people being better supported to live in their own homes (Johnston *et al*, 2008).

Aims of the study

The aims of the study were to provide information that would contribute to the understanding of the extent to which the needs of frail older people with complex health and social care needs are met at present by community and hospital services.

The objectives were:

- to describe the characteristics of a cohort of complex patients referred to the Hospital Social Work Discharge Team
- to describe contact with community services (NHS and social work) prior to emergency hospital admission
- to analyse health and social care reasons leading to admission
- to provide the discharge destination from hospital
- to establish a baseline for future studies.

Study design

The study was limited to older people living in the geographical area served by Kirkcaldy & Levenmouth Community Health Partnership (CHP) in Fife, Scotland, in order to relate more directly to strategic service improvement in the CHP. The CHP covers a mainly urban area of Fife with a total population of 96,000. Life expectancy is not significantly different from the Scottish average, multiple admission rates for hospital patients aged 65 years and over are significantly lower than average, but the area has significantly higher than average rates of people living in the most deprived areas of Scotland (ScotPHO, 2008).

The study was carried out jointly by a team manager from the Hospital Social Work Discharge Team and a research officer from the Department of Public Health. The study was guided by a steering group consisting of service managers from the NHS and Social Work Service,

consultants in old age medicine and public health, and a member of the Scottish Government Joint Improvement Team. The steering group met regularly throughout the life of the study and approved the final report. This high level of stakeholder involvement, from the design stage onwards, both strengthened and added to the legitimacy of the study.

Methodology

The evaluation examined in detail 30 complex hospital discharge patients from the caseload of clients open to the Hospital Social Work Discharge Team in January 2009. Complexity was defined pragmatically as frail older people with a range of health and social care needs who required assessment and care management by a social worker in order to achieve discharge. These patients were all considered to be delayed discharges, given that their discharges required planning beyond the date on which they were medically fit for discharge. Five of the group of 30 were randomly selected for more detailed investigation of their health and social care circumstances prior to admission, and were written up as case studies.

Information on patient demographic data, health information and service involvements was gathered from a range of NHS, Social Work Service and Partnership electronic databases in local use. Paper case notes held by community-based NHS services were also consulted for the five case studies.

Approval was obtained from the NHS Fife Caldicott Guardian in order to gain access to patient-identifiable data. Patient-identifiable data were used only to link health and social work data; once the data were linked, all patient-identifiable information was removed and each case was allocated a unique identifier. This study was classified as a service evaluation, and therefore approval from the NHS local research ethics committee was not required.

The study was not designed to gather patient and carer experiences, or other more qualitative data.

Findings

Patient characteristics (Table 1, below)

Of the 30 patients in the study cohort, 67% were female and 70% were aged 80 years or older (mean = 84 years, with a range of 71–99 years). Sixteen of the 30 patients lived alone.

Deprivation

Deprivation is characterised by applying the Scottish Index of Multiple Deprivation (SIMD), based on neighbourhoods, to the Fife population and then dividing the population into five groups (quintiles) of data zones, with quintile 1 being the least deprived category and quintile 5 the most deprived. The majority of patients (77%) came from neighbourhoods classified as more deprived (SIMD categories 4 or 5). This figure is greater than expected, given that only 59% of those aged 65 years and over live in these relatively deprived local neighbourhoods in the Kirkcaldy & Levenmouth CHP area.

Time of admission (Figure 1, opposite)

Just over half of patients were admitted to hospital outwith normal working hours (Monday–Friday,

09.00–17.00), with a large number of patients admitted to hospital on Monday evening and Tuesday morning. While very few admissions took place on Saturdays and Sundays, the findings were supportive of local anecdotal accounts that patients experiencing difficulties over the weekend deferred contacting their general practitioner (GP) until the start of the working week.

Reason for admission

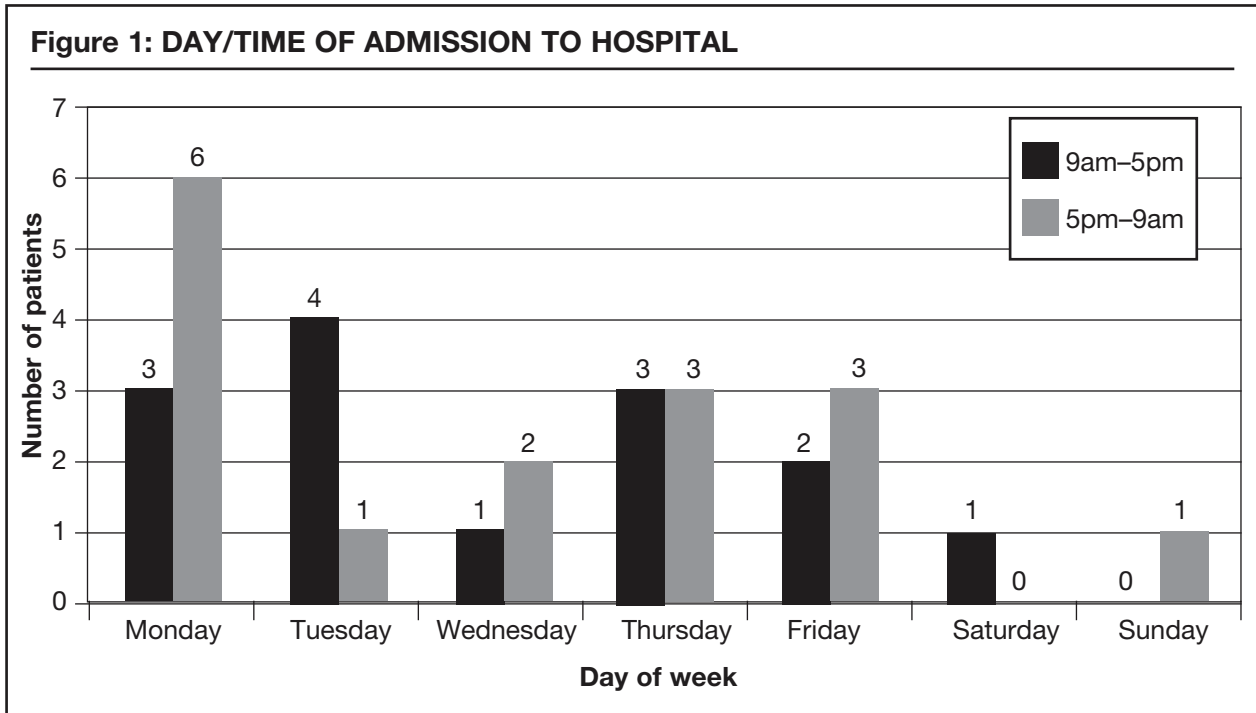
The main reasons for admission were gathered by examining NHS and Social Work Service records. NHS records provided diagnoses on admission, but not necessarily the reason why the patient was admitted to hospital, the most common diagnoses being some kind of cognitive impairment, fall, faint and fracture. Most patients in the cohort had a range of co-morbidities. The most common reasons for admission recorded on social work records were fall, mobility problems, fracture and confusion.

Previous emergency admissions

Fifty per cent of the patients had been admitted twice or more as an emergency in the previous 12 months. Of these 15 cases, six patients had not received a single shared assessment prior to the latest admission.

Table 1: CHARACTERISTICS OF 30 COMPLEX PATIENTS

		<i>N</i>	
Gender	Female	20	(67%)
	Male	10	(33%)
Age band	70–74	1	(3%)
	75–79	8	(27%)
	80–84	10	(33%)
	85+	11	(37%)
Living circumstances	Lives alone	16	(54%)
	Lives with others	14	(46%)



Cognitive impairment

When NHS and Social Work Service Records were combined, the vast majority of patients (28 of 30) were assessed as having a level of cognitive impairment, or a diagnosis of dementia which had an adverse impact on their daily living skills. NHS records indicated that 19 patients had received a diagnosis of dementia within the 12-month period prior to their latest hospital admission.

Contact with community social work services

The majority of patients had previous contact with social care services, 60% having received a home care service and 67% occupational therapy (for aids and adaptations) in the six months prior to admission. Eight patients (27%) had some contact with a qualified social worker in this period, but were not allocated as an ongoing case to a social worker at time of admission.

Contact with community health services

It proved more difficult to determine contact with community health services prior to admission

for the cohort of 30 patients, due to the lack of electronic databases in the community teams. However, paper files were consulted for the five case study patients and revealed that all five patients had some contact with their general practitioner, three had support from intermediate care services (providing rehabilitation and in one case nursing care), and only one of the five was recorded as having district nursing input.

Length of stay

This cohort of 30 patients with complex needs had lengthy in-patient stays, all but one patient having a total stay of over six weeks, and 30% having stays of over six months. Total in-patient stay ranged from 37 days to 402 days (mean = 152 days; median = 130 days).

The patient's hospital journey can be split into two broad phases: the treatment phase and the discharge planning phase (the time between the patient's being deemed medically fit for discharge and the actual discharge date).

Fifty-three per cent of these patients were in hospital for over eight weeks before being

medically fit for discharge (mean = 106 days; median = 97 days, range = 13–251 days). The discharge planning phase for the 30 patients ranged from 11 to 179 days (mean = 46 days; median = 39 days), 53% of patients experiencing a delay of over six weeks in this phase. The reasons given for the more lengthy delays were waiting for a guardianship order under the *Adults with Incapacity (Scotland) Act 2000*, or waiting for a suitable care home placement, where an interim care home placement was considered unsuitable on medical grounds.

Discharge outcome

Only two of the 30 patients returned to their own home. Three patients died before discharge. The majority were discharged to a care home (six to a residential care home and 19 to a nursing home).

Discussion

The findings of this paper raise a number of issues that must be addressed in order to boost the effectiveness of the whole health and social care system relevant to meeting the needs of frail, older people with complex needs in the community and in hospital. The results of this joint health and social work study are being used to influence service improvement across the health and social care partnership. While there is a substantial amount of patient/client-related data held in a number of paper and electronic data systems, accessing and merging data was very time consuming, with data often collected in a format unsuitable for subsequent quantitative analysis.

Internationally, hospitals are seen as an important entry point for institutional care (Karmel *et al*, 2009). Transitions across organisational boundaries frequently create challenges for the staff working in these organisations, and are often accompanied by uncertainties and anxiety for patients and their informal carers (Petch, 2009).

A comparison of the differing policy approaches to tackling delayed hospital discharge in England and Scotland concluded that, despite the differences, there was increasing awareness in both countries of the need not only to invest in hospital throughput, but also to direct resources into community infrastructure, including intermediate care (Godfrey & Townsend, 2009). Tackling delayed hospital discharge requires a whole-systems approach (Baumann *et al*, 2007).

Intermediate care is one component of the whole system and is a broad term used to refer to services that prevent unnecessary hospital admission, facilitate timely hospital discharge, and prevent premature admission to institutional care. The development of intermediate care has not been without difficulties. The potential of these new services has frequently not been realised because they were often insufficiently linked to mainstream services (Glasby *et al*, 2008). Significant progress has been made in recent years with intermediate care services in Scotland, Fife being one of five local authorities funded by the Scottish Government Joint Improvement Team as an Intermediate Care Demonstrator site. The grant has allowed for the development of three work strands: extended hours for intermediate care services to offer more accessible services at evenings and weekends, a pharmacist to advise intermediate care staff on medication issues, and workforce training and development to develop skills and knowledge. The project will be evaluated after one year in the summer of 2010.

Care management for older people with community care needs is regarded as one of a range of service elements that contribute to the support of people in the community and help to avoid delayed discharges (Baumann *et al*, 2007). Despite the overall high level of contact with health and social care services for this cohort of patients, there was insufficient evidence of a co-ordinated approach to managing their

needs in all cases. The Partnership for Older People Projects (PSSRU, 2010), funded by the Department of Health in England, demonstrated that pro-active case co-ordination services can substantially reduce visits to A&E departments and hospital stays. There was some indication from the five case studies that services had difficulties in engaging with some older people with cognitive impairment and frailty who were refusing to accept help. Given the levels of dementia in the study group, it needs to be considered whether in some cases services for older people could adopt a more assertive outreach approach to engagement.

Health inequalities are a major focus for government action across the UK, and the links between health outcomes and deprivation are well established. However, despite government interventions, health inequalities in Scotland have widened in recent years (Macintyre, 2007). A substantial body of evidence shows that health inequalities continue in older age, regardless of which measure of socio-economic circumstances are used (West *et al*, 2004). Frail older people admitted to hospital in one English study were found to have clinical syndromes of confusion, deteriorating mobility, incontinence and falls (Young *et al*, 2005). Apart from incontinence (which was not recorded), these characteristics were evident on admission of the cohort of patients in our study. A significant association has been found between deprivation and hospital admission for falls in adults aged 75 years and over (McMunn *et al*, 2006), and again our study provides further support for such links, showing a greater than expected hospital admission rate for older people from the more deprived neighbourhoods.

There is also a suggestion that discharge outcome may have an association with deprivation. Connolly & O'Reilly (2009) undertook a major study of 28,000 older people admitted to care homes in Northern Ireland,

and found variation in admission rates by geographical localities. The numbers in our own study were too small to allow tests of statistical significance, but the trends were similar to those found elsewhere, with patients from more deprived areas in the locality more likely to be discharged from hospital to a care home.

Carer support needs to be addressed in more detail. The study found that 46% of the cohort of 30 patients lived with a partner or other relative, but did not directly address the support provided by these informal carers, nor the extent to which carers were involved in discharge planning. Family members frequently report dissatisfaction with their involvement in discharge planning (Bauer *et al*, 2009). The report from the Social Care Institute for Excellence makes clear the crucial role of informal carers in supporting vulnerable older people in the community and the need for them to be closely involved in discharge planning (SCIE, 2005).

Conclusion

This study describes contact with community and hospital services prior to the most recent admission, charts the patient journey in hospital, and provides the discharge destination for frail older people with complex health and social care needs who have experienced a delayed discharge.

This paper demonstrates the strengths of a partnership approach to service evaluation in the area of hospital discharge for frail, complex, older people. The authors were able to combine several different datasets from the NHS and Social Work Service which, when analysed as a whole, provided useful information relating to both hospital and community services.

In Fife, as in other parts of the UK, there is a drive towards developing services for older people aimed at improving their health and well-being, and promoting independence to prevent or delay unnecessary use of hospital and institutional care. This study has contributed

to the local knowledge base to inform strategic policy decisions relating to the development of community services, including intermediate care.

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