Position Paper
Addressing the Challenge of Delayed Discharges from Hospitals

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In 2018, The Minister for Mental Health and Older People Jim Daly TD, established a Working Group to carry out an independent expert review of delayed discharges. This is one of the many challenges and opportunities that needs to be addressed as we all age, and age in greater numbers in the years ahead. There is a growing need for care pathways, management frameworks and better diagnostic frameworks for people living with chronic long term conditions like frailty and dementia. The Clinical Programme for Older People has been in the vanguard of such developments over the past number of years. The welcome recent appointment of a National Clinical Advisory Group Lead for Older Persons in the HSE is recognition of the leadership and development need in this area.

The WHO Global strategy and action plan on ageing and health (2016 - 2020) advocates for major reform to healthcare systems to empower healthy ageing across the life course. Public health initiatives, policy and data are obviously of critical importance to this work. The delayed discharge review had the potential to shine a light on the broader challenges that we face in supporting older people to live independently in our communities. The overall purpose of the review was to identify changes that can be made in the short to medium term to minimise delays in patients returning home from hospital or to a more appropriate care setting, reduce hospital bed days lost to delayed discharges and to better address patient needs.

Following consultation with our stakeholders and other interested parties, The Irish Gerontological Society made a submission to the Working Group outlining our views and concerns.

The development of our submission generated a level of interest and engagement such that our discussions continued long after our submission was made. Our deliberations have resulted in the publication of this comprehensive position paper Addressing the Challenge of Delayed Discharges from Hospitals.

We should look at this a start for our society. We have a great opportunity, as a truly interdisciplinary organisation to make further contributions in advocating for and influencing how improvements and progress can be made in our society and how it supports all of us as we age.

We propose 7 key recommendations of our own as to how discharge supports could be enhanced in the community:

i. Ready and speedy access to Home Care Supports from the community and hospitals
ii. Increase in Integrated Care Teams
iii. Appropriate numbers of adequately staffed in-patient rehabilitation centres
iv. Extension of early supported discharge programme
v. Functioning well supported day hospital services
vi. Nursing home care suitable for complex care needs, with increased in reach and outreach service provision to all nursing home services
vii. Acute Medical Units that are gerontologically attuned and can meet the needs of the frail older person using the service

Summary of the Working Group’s Recommendations:

1. Develop a national policy to provide a clear definition and guidelines for categorising DDs and replace the term “Delayed Discharge” by “Delayed Transfer of Care”;

2. Take steps to improve data quality and extend the DD dataset to non-acute healthcare settings and shift the focus of DD reporting to bed days lost and look at other methods of measuring the number of DDs e.g. Netherlands, England, and Scotland;

3. Set up a Joint Planning Forum between acute hospitals and community services to develop a shared view of demand and capacity needs and strategic responses to gaps in service;

4. Review roles and responsibilities to assess the support for patients and their families on the NHSS process and clarify accountability lines of stakeholders responsible for managing DDs;

5. Undertake an external data audit to review quality compliance, improve data quality and visibility and increase confidence in the data available;

6. Launch public health campaign to raise awareness that patients who are discharged without delay have better outcomes and establish a consistent approach and timed pathway for communicating with families (next of kin) to minimise potential delays;

7. Establish multi-disciplinary teams to conduct single discharge assessments. These teams should be supported by staff both in the acute healthcare setting and in the community;

8. Encourage information sharing between Hospital Groups and CHOs on bed availability and patients’ status and adopt an integrated ICT system, capturing supply and demand in both acute and non-acute healthcare settings;

9. Establish early discharge pathways to prevent admissions and reduce delayed discharges, which in turn will enable assessment of care needs in the patient’s home or alternative care setting.
Introduction

The increase in successful ageing of older Irish adults is notably changing Irish demography and the characteristics of users of Irish health services. While most older adults are independent, older people are the biggest users, proportionately, of acute in-patient services. Older people will need access to hospital care and services in the community at various stages of their later lives.

Older people increasingly present with complex syndromic conditions rather than single organ diseases. These geriatric syndromes include frailty, complex comorbidity, disability, Parkinson’s Disease, delirium and/or dementia. In addition, older people often present acutely unwell and scoring high on acute illness severity scales, which can be an independent predictor of loss of functional capabilities. These syndromes can be further complicated by complex psychosocial circumstances, which influence discharge planning.

A comprehensive approach to the assessment, rehabilitation, planning and support for discharge is required to enable older people to return their homes, and less frequently to nursing or residential home care. A key element of this multidisciplinary biopsychosocial approach is the Comprehensive Geriatric Assessment (CGA).

A Meta-analysis of 22 trials showed that CGA has long-term benefits for inpatients’ survival and independence for months after they leave hospital. Optimum outcomes from CGA requires access to appropriate multidisciplinary rehabilitation and community based social supports.

Improving Quality of Care for Older People

The National Clinical Programme for Older People (NCPOP) has published a number of documents examining the delivery of acute care to meet the growing needs of older people. These documents covered the Acute Model of Care (2012), CGA (2016), Urgent Care Needs for Older People and Frailty at the Front Door (2017), and the Integrated Care Programme: a 10-step guide of how health and social care services can be designed and developed.

During Hospital Stay

Patients over 65-years-old account for a significant proportion of in-patient admissions (32%) and acute hospital in-patient bed days (53%), with over 85-year-olds accounting for 13% of in-patient bed days. Up to one in four acute beds are occupied by someone with dementia: of which only half are diagnosed prior to admission.

Multimorbidity or Comorbidity (multiple health problems) is the norm in patients over 65 attending the Emergency Department: conditions such as dementia, stroke, heart disease and diabetes.

Multimorbidity and frailty is highly predictive of hospital admission and re-admission from the community. Looking after this patient cohort, and the inherent and integrated restoration of functional loss as well as post-discharge support, should now be considered the core business of all acute hospital services – emergency, medical and surgical services – and community services.

The skills of the workforce, including primary care and the hospital environments in addition to the processes of care in the community, need to be gerontologically attuned to meet the care needs of the growing population of frail older people. Acute hospitals and their affiliated communities that ‘get it right’ for the most vulnerable are more inclusive, and likely to ‘get it right’ for everyone else. This will improve the patient experience, the patient outcomes and the job satisfaction of health care professionals.
Assessing Risk of Functional Decline

Most older patients admitted acutely to hospital have some functional impairment already, and the vast majority survive the hospital admission. The majority of older patients admitted to hospital regain their normal functional ability and can be discharged as soon as they recover with their pre-existing supports in place.

However, one-third lose some ability in common activities such as standing, walking, or dressing while in hospital. Patients who experience significant functional decline during their hospitalisation are then in need of additional treatment and social supports, and the latter are often sourced from the hospital into the community prior to hospital discharge. The risk of Hospital-Associated Functional Decline (HAFD) depends on various factors: patient pre-admission vulnerability (e.g. frailty, cognitive impairment), the severity of the illness or stressor that patients present with (e.g. sepsis, delirium) and also the hospital processes of care (e.g. whether older patients have timely access to CGA) (Figure 1). The relative contributions of these factors to the amount of HAFD are not well understood and this is the subject of ongoing research6.

Figure 1. A model of hospital-associated functional decline in hospitalised older adults
Although their acute medical problem may have stabilised, many older people may return home not quite as able as they were when they were admitted to hospital, thus short of their usual functional baseline. So most need, and benefit from, a clinician-led, medically directed multidisciplinary approach to recovery of this functional baseline, involving health and social care professionals (including physiotherapists, occupational therapists & PHNs). Optimum care should therefore delay discharge until it is clear that in-patient function has been maximised to the point of facilitating discharge to home. This may occur in general wards, geriatric medicine wards, or Category 2 hospital beds under direct medical supervision, usually by physicians in geriatric medicine. Even with this in-patient multidisciplinary input, a proportion of these patients will require a home care package to support their discharge and community-based therapy for ongoing recovery. Data from The Irish Longitudinal Study on Ageing (TILDA) shows around 8% of older Irish adults require support from paid carers.

A minority of patients will necessitate admission to care homes (residential or nursing), despite appropriate remediation attempts. With population ageing, there will be a predictable need for annual increases in the provision of all these supports, notably paid carer support through home care packages and care home placements.

Delayed Discharges

The current crisis in hospital patients awaiting in-patient rehabilitation, community rehabilitation, home support packages, and suitably tailored care-home beds has led to what is sometimes termed ‘delayed discharges’. This negative term implies action or inaction affecting the ability of an older person to be discharged from an acute hospital. There is a sense that vulnerable patients and their families are preventing access to healthcare services for others, by failing to leave the acute hospital in a timely fashion. It may also imply a certain level of inaction by health-care professionals involved in the care of patients. The lack of appropriate post-discharge support and rehabilitation or long-term care facilities is the fault of the system, not of vulnerable older people. A more appropriate phrase is "Discharge Support Failure". Health-care professionals, older people and their families are acutely aware of the possible poor outcomes for frail older people staying longer than is necessary in acute hospitals.

A proportion of delayed patients may experience physical ‘deconditioning’ due to being subjected to processes of hospital care that they no longer need which may restrict usual levels of physical activity, impair their sleep, increase the risk of hospital-acquired infections, iatrogenic events and/or negatively impact upon their psychological wellbeing. The feeling of being a ‘bed-blocker’ can often add stigma to a situation that is no fault of their own.

It is important to acknowledge that most older people will not chose to remain in hospital, when they have recovered sufficiently for their care to continue in the community. However, if a person was continent, mobile and clear in mind before hospital admission, and is now impaired in all three areas, there are clearly medical and care issues that remain to be addressed through diagnosis, treatment, rehabilitation and support prior to discharge. As medical and health-care professionals we must all look beyond the specific medical and surgical procedures and address the care of older adults more systematically and holistically, like we would like our older relatives to be looked after.

Equally, the lack of appropriate post-discharge support and rehabilitation or long-term care facilities is the fault of the system, not of vulnerable older people. A more appropriate phrase is "Discharge Support Failure".
Addressing Discharge Support Failure

A wider vision of integrated, age-attuned services is needed across the spectrum of healthcare in Ireland to lessen morbidity and reduce acquired functional loss among older people, from integrated care teams, community and hospital-based rehabilitation to timely provision of home care packages. This vision is outlined in part by documents from the National Clinical Programme for Older People - the Acute Model of Care document (2012), a document on CGA (2016), a paper on Urgent Care Needs for Older People, Frailty at the Front Door (2017) and along with the Integrated Care Programme “Making a start in Integrated Care” (2017). In the immediate short-term, five aspects of care provision need to be urgently revised to address discharge support failure:

(i) Ready and speedy access to Home Care Packages;
(ii) Adequate numbers of adequately staffed in-patient rehabilitation centres;
(iii) Extension of early supported discharge programmes;
(iv) Functioning well supported day hospital services and;
(v) Nursing home care suitable for complex care.

In addition, there is a need to adapt the processes of acute hospital care for those who experience a delayed discharge, in order to avoid preventable functional loss in a subgroup of patients.

(i) Ready and speedy access to Home Care Packages:
In many Community Healthcare Organisations (CHO’s) there has been an effective freeze in the allocation of Home Care Packages. One Dublin teaching hospital estimated that on any day over 20 patients could be discharged if their Home care package was available, and this is replicated across the country. This cause of “Discharge Support Failure” directly adds to the number of patients on trolleys every morning. The demographic changes in the Irish population mandate an annual increase in funding to match the levels of disability to reduce inappropriate time spent in hospital.

(ii) Adequate numbers of adequately staffed in-patient rehabilitation centres:
There is a major deficit in appropriately staffed (geriatricians, gerontological nurses, physiotherapy, occupational therapy, psychiatry of old age, clinical nutrition, speech and language therapists and social workers) and resourced in-patient rehabilitation units, lagging far behind the modest levels specified in The Years Ahead, the now almost historic 1988 blueprint for healthcare for older people.

The Acute Model of Care document, published in 2012 by the NCPOP on behalf of the HSE/RCPI, outlined in further detail the requirements that need to be met. In response to a request from the Social Care Division to the National Clinical Programme for Older People (NCPOP), an appendix was added to the Acute Model of Care document (2012), describing what it considers is an appropriate response to the requirements of Older People following a functional deterioration and/or an acute illness in terms of onsite and offsite rehabilitation beds with appropriate complements of suitably qualified staff. This appendix also outlines the definitions around these type of beds and the therapy hours and staff which are needed to support patients through this ongoing rehabilitation and recovery process. Work is ongoing to progress this.

The situation is complicated by the persistence of inadequately staffed and directed facilities labelled as “step-down/short-stay/convalescence”. The acid test of any such service is whether they would serve the needs of a younger patient cohort – for example young orthopaedic trauma patients. In addition, “transitional care” beds are utilised for a small minority of older people who have completed care – acute or rehabilitation care – and who cannot return home or to appropriate long term nursing home placement. The danger in this situation is the temptation for stretched hospitals services to send people to these beds who actually require rehabilitation.
A key priority in resolving the current bed crisis is the urgent development of such units to support general hospitals, with appropriate complements of suitably qualified staff.

As previously noted, the NCPOP has produced a document outlining the definitions around these type of beds and the therapy hours and staff which are needed to support patients’ ongoing rehabilitation. In the *Urgent Care Needs for Older People, Frailty at the Front Door* document there is specific reference to the need for a focus on the role specialist geriatric services, inpatient rehabilitation, discharge planning, day hospitals and community services can play in supporting appropriate discharge after illness for the increasing number of frail older adults who require acute hospital care. Some of these services can also support older people to remain at home in their community without needing to attend acute hospital services.

The model we advocate is older patients receiving access to appropriate rehabilitation while in hospital. As soon as possible, patients are discharged home with ongoing rehabilitation (an example being ESD below) and a home care package. With reablement, the level of care needed can be reduced as patients regain independence. This reduces length of stay, long-term disability and is more cost-effective than adding extra hospital bed capacity.

It is likely that public and voluntary services are the appropriate setting for any new initiatives.

(iii) Extension of early supported discharge programmes:
The Early Supported Discharge (ESD) scheme has been successful for facilitating earlier discharge for a minority of patients with stroke: a wider rollout of this scheme should prove of benefit for reducing discharge support failures. The National Clinical Programme for Stroke has submitted advanced plans for teams in multiple hospitals that could be in place within weeks of funding approval. Pilot programmes in several hospitals have demonstrated these programmes do work in Ireland.

(iv) Functioning well supported day hospital services:
The future of the Day Hospital is likely to remain clinically focused but given its flexibility, it can take on a new role as a connector ‘hub’ linking primary, secondary, social and public health care, promote the use of new ICT advances to monitor and manage the care of community-dwelling older adults and advance educational initiatives and eHealth literacy to encourage active and healthy ageing well into the 21st century. The Day Hospital also has the capacity to be the bridge between the community and acute services. As the evidence base for interventions grows the day hospital may act as a focus for measures to promote active and healthy ageing and target pre-frailty and frailty at its earliest stages in order to prevent functional decline and established frailty. The frailty syndrome (and measures based around it) has the potential to become an advocacy tool and a key lever for change. It enables us to explain the need for delivery of specialised care to older adults and why their outcomes are variable and respond differently to many health care interventions. It can also potentially be used to promote a system wide integrated programme of education, which could be based around the existing model of the Day Hospital.
(v) Nursing home care suitable for complex care:
The current spectrum of nursing home care available does not facilitate admission of patients with complex care needs, particularly those with behavioural and psychological signs of distress. Patients have been known to wait over a year for a suitable place, and there needs to be a significant development of nursing home places equipped to cater for this complex care, as well as potential creative funding schemes across the pillars of the HSE to fund the personalised care required, sometimes on a one-to-one basis. This patient population requires easy access to specialist care. This needs to be facilitated with an appropriate tariff to incentivise private nursing homes to provide this service. If not, a nationally funded programme is required. The evolution of in-reach and outreach nursing home services needs to continue and be supported.

Hospital approach: Identification of the complex needs of frail older patients presenting acutely to emergency departments is also crucial. Hospital care pathways and environments should be orientated to support and maintain continence, physical and cognitive functions of frail older patients admitted to hospital. It is also important that acute hospital staff and the processes of care are attuned to maximise the independence and wellbeing of those who are experiencing a delayed discharge, and especially those who are in need of further rehabilitation and home care packages, because they are at higher risk of potentially avoidable loss of function and complications whilst waiting in the hospital. In UK hospitals, this has taken the form of hospital and national campaigns focusing on “use it or lose it” and “end pyjama paralysis”.10,11,12 While this is already resonating in Irish hospitals, successful implementation across the acute sector requires additional policy leadership and resources. The rigorous evaluation of this type of initiative is a major focus for quality improvement in the care of hospitalised frail older adults. Such initiatives are also likely to become a catalyst for gerontologically attuned care, boost staff morale, and improve satisfaction of patients and their families.
The Cost of Care and Support at Home

The frequently asked question now in all health and social care systems is how to support dependent older people living at home for longer, rather than be admitted to expensive acute care or long-term care facilities. A minority will need care in a nursing home, and these care services do need to be fit for purpose.

It is acknowledged that care within the home for frail older people fits with the desires of older people to be managed in their own homes, in their own communities for as long as possible. Therefore a significant investment in care that can be delivered in the home and in the community can have a significant impact on more costly care received in acute hospitals and in nursing homes. A minority of older people require care within a long-term care facility, but with changing demographics, it must also be acknowledged that significant investment will also be required in this sector.

For example, there is encouraging evidence for Ireland that enhanced, personalised, community-based supports keeps people with dementia living in their own homes for longer. There is currently a mismatch between government policy stating the desire to support older people in Ireland at home for longer, and public spending between residential care and community-based care.

Currently, the government is spending more than twice as much on residential care than on home care support for people with dementia, €962m relative to €408m annually.

Research currently being undertaken at the Centre for Economic and Social Research on Dementia (CESRD) at NUI Galway indicates that investment in intensive home care packages (IHCPs) is cost-effective, especially when compared to alternative provision. In terms of the economics of care, the average weekly cost of IHCP-enhanced community-based care is cheaper than residential care placement; CESRD estimates suggest that IHCP-enhanced provision is less than two-thirds of the weekly cost of public long-stay care. Of course, adding unpaid family carer costs raises the average cost of home care significantly, given the reliance on families in community-based care.

However, even when all social costs are included, keeping dependent older people living well in their own homes is still less than half the weekly cost of a bed in an acute hospital.

Investment in intensive community-based supports for dependent older people living at home is, therefore, good value for money for the public sector, especially for people on the boundary between community and residential care. The growing market for private care should also be noted, particularly the potential for inequities to develop as that market evolves.

Universality, efficiency and fairness should be the key principles underpinning reform of home care in Ireland. In the long-run, developing a personalised, high quality, care model in the community will impact positively on all sectors of the health care system, particularly the acute care sector.

If we want to support and care for dependent older people for longer at home, as a society and government we will have to invest to meet this growing need.
Conclusion and Recommendations

The IGS position paper has outlined common causes of failure to support discharge in the design and funding of health and social care in Ireland. We have also provided evidence-based solutions based on Irish research and shown that, when funded, programs like ESD and IHCPs can deliver results. The recurring nature and challenges of this issue will persist until we plan for the well-described aging of our older (and younger) adult populations and the services to meet their needs are implemented along the lines outlined here. If we want to support and care for dependent older people for longer at home, as a society and government we will have to invest to meet this growing need.

The IGS recommends action in order that the following aspects of care provision be urgently revised to address patient care, patient flow and discharge support failure:

i. Ready and speedy access to Home Care Supports from the community and hospitals
ii. Increase in Integrated Care Teams
iii. Appropriate numbers of adequately staffed in-patient rehabilitation centres
iv. Extension of early supported discharge programme
v. Functioning well supported day hospital services
vi. Nursing home care suitable for complex care needs, with increased in reach and outreach service provision to all nursing home services
vii. Acute Medical Units that are gerontologically attuned and can meet the needs of the frail older person using the service

In addition, there is a need to adapt the processes of acute hospital care for those who experience a delayed discharge, in order to avoid preventable functional decline in this subgroup of patients.
References


3. HSE (2017) Urgent Care Needs and Frailty at the Front Door.

4. HSE (2017) Making a Start in Integrated Care for Older People. Integrated Care Programme for Older People, 10 Step Framework.


7. HSE and RCPI (2016) National Clinical Programme for Older People, Categorization of Short Stay Beds.


Transforming ageing ..

Founded in 1951, The Irish Gerontological Society (IGS) is one of the oldest multidisciplinary societies in the world concerned with gerontology: the science and study of the ageing process. We are engaged with research, education and practice in the field of ageing. This includes the study of changes in older people's physical and cognitive health, and the social changes people experience as they age.

..through new, useable, research-based knowledge..

Our core purpose is to create value by providing leadership in advancing the science and study of ageing.

Our role is to connect professionals and experts; foster new research; translate research evidence into policy and practice; and disseminate new knowledge to our members, decision-makers and society. In doing this, we drive improvements in the care and wellbeing of older people.

..and interdisciplinary and cross-speciality engagement and collaboration..

Members of the IGS stem from the whole of Ireland, representing professions and disciplines involved in areas such as health and social care, economics, the social and built environments and technology.

..towards improvements in the wellbeing, health and care of older people..

As champions of optimal ageing, we strongly believe in the strength and impact of our combined expertise and efforts. Our members connect, collaborate and network at our scientific meetings, seminars and study days. Engagement is encouraged and enabled through attendance at our events and participation in our committees, project teams, and special interest groups.

..for a better world for everyone which is age-attuned.

We stimulate debate and action on improving the well-being and empowerment of older people. We contribute to public discussion by being an authoritative voice on all aspects of ageing, informed by evidence-based research and professional practice experience. We do this in pursuit of our vision of an age-accommodating and age-attuned society, where older people are not left behind.