Understanding safe discharge of patients with dementia from the acute hospital

Pressure to discharge inpatients with dementia has heightened. Driven by understandings that the acute hospital is often unsafe for patients with dementia (Marshall, 2001), the clinical question on the ward all too frequently may not relate to diagnosis but rather when can a patient go home? Unfortunately discharge can be an emotional complex process, made all the more problematic when a patient has dementia and thereby presents today's clinicians with unparalleled challenges. This editorial considers discharge at a conceptual level, reviews the evidence for discharge in relation to patients with dementia, considers new innovations and concludes with a pragmatic strategy designed to increase the probability of a successful safe discharge.

Conceptual considerations

Three key conceptual considerations are central to understanding how to plan for a safe hospital discharge, not only for patients with dementia but the wider population. First, the assumed goal of a successful discharge is to reduce length of stay, prevent readmission and ensure a seamless transfer and coordination of post-discharge services. Second, in considering why there is such a focus on discharge, not only is it because of reduced economic costs but importantly safe discharge is increasingly being viewed as a marker of the technical efficiency of the acute hospital settings. Third, although we may seek to ensure a safe discharge on all occasions, clinicians need to be aware that the outcome of discharge will invariably be multifactorial and importantly there will be factors that cannot be mitigated for, despite best planning.

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In terms of understanding what influences length of stay it is helpful to breakdown factors into four areas as defined by Martin and Smith (1996): patient characteristics, hospital characteristics, social environmental factors and clinical practice. Interestingly, Martin and Smith (1996) suggested that the greatest variation in terms of discharge related to older people.

Of these four areas, clinicians have the greatest degree of influence over clinical practice. In relation to hospital clinical practice for patients with dementia and delirium, an in-depth qualitative study (Teodorczuk et al, 2013) has identified the main areas of practice gaps across the health-care spectrum. The grounded theory study suggested that technical practice gaps, such as discharge, were underpinned by core level practice gaps such as degree of ownership of patients with dementia, carer partnerships, communication and negative attitudes towards this challenging group. Put another way, for a discharge to succeed the less technical practice gaps need to be met in order to ensure that good care can proceed. Unfortunately this assumption cannot always be made and therefore as a foundation to ensure safe discharge positive leadership, joined-up interprofessional care and good carer partnerships must be advocated first (Teodorczuk et al, 2015).

Review of the evidence

What does the evidence tell us about discharge from hospital? An oft-quoted review of discharges of patients more widely, analysing 21 randomized controlled trials, suggests not surprisingly that there is much variation across different countries within different systems of care (Shepperd et al, 2010). However, although it failed to demonstrate specific benefits on health outcomes, it did show that tailored discharge planning can reduce readmission rates and length of stay. Further evidence into readmissions in the USA, again for patients without dementia, showed that, across all discharges, readmissions were high at 20% and concluded that some readmissions might be unavoidable in part (Jencks et al, 2009). Specific risks for readmission include having over six chronic conditions, polypharmacy and medication errors.

But what of patients with dementia? A study by Saravay et al (2004) demonstrated that patients with dementia and delirium do indeed have greater length of stay than other patients, this relationship being causal rather than casual. These findings have been supported by the Counting the Cost report which estimates that patients with dementia have on average an increased length of stay of between 5 and 7 days (Alzheimer's Society, 2009). Potential reasons for increased length of safety include non-compliance with diagnostic tests, and poor compliance with rehab and medications, so-called 'aberrant behaviours'. Further issues specific to patients with dementia include the increased vulnerability to delirium and likelihood of discharge to nursing homes; both key mediators of length of stay.

In a similar manner the evidence suggests that, compared to other patients, those with dementia have higher readmission rates. A US Medicare retrospective cohort study demonstrated a significantly greater odds ratio of readmission for patients with dementia at 1.18 (Daiello et al, 2014). Greater odds were especially associated with use of antipsychotics and discharge to a nursing home. Potential reasons at a theoretical level include the fact that patients with dementia are less likely to benefit from discharge education, adhere to instructions or report symptoms. Furthermore, it is already established that patients with dementia already are more likely to be admitted to hospital and therefore readmission rates are higher for this vulnerable group.

Innovations

Proactive approaches to tackle the issue of discharge and reducing length of stay and readmissions are increasingly being explored and represent the holy grail for many hospital trusts. As such, much has been written about

the Discharge to Assess approach championed in Sheffield (Health Foundation, 2013). Results of this innovation, which involves discharging patients home as soon they are declared medically fit for further nursing and allied health assessment to proceed in the community, are encouraging. Equally encouraging are the initial findings of the Royal Free My Discharge approach specifically targeted at improving safe discharge for patients with dementia (Health Foundation, 2014). This innovation, funded by the Health Foundation, involves appointing an occupational therapist whose sole role is to coordinate discharges for patients with dementia in a positive manner and ensure that discharge processes are effectively followed. Early results for the My Discharge project again are good with reported reduction in length of stay by 1.9 days and 26% reduction in reattendance to the accident and emergency department.

However, in consideration of both approaches it may not be the redesign that is the active ingredient but rather the increased focus on the non-technical practice gaps previously identified. For example, in the case of the My Discharge project it may be greater ownership of the patient by the occupational therapist that has led to more effective results.

Further caution needs to be adopted when reviewing findings of these innovations. Length of stay and readmissions may not necessarily be the only markers of a successful discharge. Equally important are patient and carer satisfaction. As suggested by Goldberg et al (2013) following the TEAM NIHR trial, perhaps hospital or discharge experience may be as important as length of stay or readmissions. Traditional metrics of length of stay and readmissions may be driven as much by capacity of services and families and frailty of the patient, rather than quality of care processes.

Practical interventions

So what can be done to increase the probability of a successful discharge? As proposed by Kane (2011) safe discharge is not an exact science and a structured methodological approach, recognizing that many factors cannot be mitigated for, is essential.

With this in mind a four-pronged approach is proposed specifically to address the issue of safe discharge of patients with dementia. First, it is important to consider discharge as a process rather than an end point and as such planning the pre-discharge, bridging and post-discharge processes is essential from admission. Second, there is a need to personalize discharge plans and ensure that the discharge destination is appropriate for the patient, a decision made based on diagnosis, rehab potential, support and risks at home. Third is the need to ensure that capacity is assessed at the right time and that best interests decisions are made in meetings involving the right people. Discharge destination capacity assessments have been seen as a critical event and therefore they must be undertaken by the right person at the right point in illness to give the patient the best chance to demonstrate capacity (Poole et al, 2014). Last, clinicians must always plan for the worst case scenario and develop collaboratively realistic contingency plans focused on reducing risks potentially with further transitions of care that might not involve readmissions. Educating staff in care homes and carers about how to manage challenges in the community in advance of their emergence is key in this situation.

Conclusions

Increasingly safe discharge is becoming an important topic not only relevant to patients and carers but also policy makers and managers. Although seen as a marker of the technical efficiency of the hospital in fact it might represent a measure of the non-technical care processes within the hospital. For patients with dementia, length of stay and readmissions are higher than for other groups, potentially as a result of the confounding influence of delirium and transition to 24-hour care settings. A pragmatic approach structured on ensuring a personalized discharge and with tight contingency plans can help increase the probability of a safe discharge. However, safe discharge is a multifactorial and complex process and a positive experience may be as important as reduced length of stay and readmission rates. **BJHM**

KEY POINTS

- Patients with dementia have greater length of stay and readmission rates.
- Key mediators of this process include delirium and transition to nursing homes.
- Developing a structured approach to safe discharge can increase the probability of a successful outcome.
- The discharge process is highly complex and many factors cannot be mitigated against despite best care.
- A positive patient and carer experience may be as important as reduced length of stay or readmission rates.

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