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Hospital Avoidance

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Background

- Admission to hospital for a person with dementia can be traumatic and can lead to an escalation in confusion, disorientation and associated behaviours. In addition the distress caused to carers can increase.
- Hospital Avoidance began as a pilot scheme on 16th March 2016.
- The purpose of the scheme was to provide specialist support at weekends (via telephone and face-to-face) in order to avoid hospital admissions for dementia patients. This later expanded Bank Holidays and three evenings a week
- The scheme supports patients from the Shropshire and Telford & Wrekin CCG areas.
- Additionally where a patient is on leave pending discharge from Oak Ward, if it is deemed beneficial to the patient and carer, Hospital Avoidance will follow up and support to prevent readmission.

Patient Journey Research

- Research suggests that increased hospital stays can have a negative effect on people with dementia including having a significant negative effect on their general physical health and on the symptoms of dementia, such as becoming more confused and less independent (Alzheimer's Society).
- Oak Ward aims for an admission period of 8 weeks and the patient journey describes what a patient can expect from admission to discharge.
- We do recognise though that all patients are individuals and patient journeys may differ slightly due to factors such as consent or changes to a patient's physical or mental health.

Your patient journey

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Within 24 hours of admission

- Care plan and Risk assessment completed and reviewed weekly throughout admission as any needs of risk change Physical health assessments including blood tests, ECG, Urinalysis, nutrition and hydration etc. will be carried out and reviewed as needed.
- A provisional discharge date will be set as 8 weeks from admission date
- Contact will be made from the ward to the NOK to provide information on the ward, visiting times and process of admission; they will also be given the opportunity to provide any information about the patient, if available this will be done by the key nurse.
- Falls assessment and referral for a physio therapy assessment; this will be reviewed if any falls occur throughout admission
  If there are concerns then a referral will be made to SALT, dietician or chiropodist based on the patient's needs and this will be reviewed throughout admission.

Within 1 week of admission

- Formulation meeting held with family and care co-ordinator to discuss and plan admission and discharge process
- Referrals will be made to social services, care co-ordination and advocacy.
- Ongoing medical assessment of physical and mental health with ward reviews carried out weekly throughout admission

Within 4 weeks of admission

- NOK will be offered 1:1 sessions at least weekly throughout admission to ensure that they are fully informed and involved in care planning.
- A nursing assessment will be completed making a recommendation of the level of care required on discharge
- An OT assessment will be completed making a recommendation of the level of care required on discharge
- A continuing healthcare checklist will be completed to assist with funding application
- A best interest/117 meeting will be held to discuss discharge planning

Within 6 weeks of admission

- Nursing home assessments will be carried out if required or a care package will be sourced if required
- A funding application will be made

Discharge

- When an appropriate placement is sought and funding in place, transfer arrangements will be made
- A transition support plan will be put into place, dependant on the level of support required

Within 7 days of discharge

- A 7-day follow-up will be completed by community nurse and they will take over the support in the community
- A discharge summary will be completed by medical team and sent to GP

Above is a description of the journey a patient can expect to go through during admission and then discharge. These timings are a guide only and are **not fixed** due to various different factors that can affect a patient in clinical situations.

What does Hospital Avoidance involve?

- Experienced staff from Oak Ward
- Telephone advice and face to face support
- Emergency Visits
- Pre-planned visit to support the person with dementia either in their own home or in Residential or Nursing Care.
- Joint visit with the Emergency Duty Team (EDT) if required
- Further support, visits or assessment can be arranged

Referral Process

- Referrals are accepted from nursing and residential homes, G.Ps , Memory Service, Access Team, pathways, EDT, and RAID
- Staff on Oak Ward complete the Hospital Avoidance checklist
- Staff on Oak Ward will assess each referral to determine the level of support required along with the level of risk
- All staff on Oak Ward who are likely to be involved in either the receipt of referrals or providing telephone or face to face support must have received an appropriate induction into the protocol and this must be recorded and put in their personal file.
- Following Hospital Avoidance input Oak Ward staff must ensure Home Treatment are informed

Gold Standard Care Plan

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In order for someone to be referred to Hospital Avoidance they must:

1. Be on CPA
2. Have a mental health care plan
3. Be a care cluster 19 or above

Referrals accepted by telephone or email but must include:

Name, address and contact number, Reason for problem, What they need from hospital avoidance, Any alerts / major risks, That the care plan and risk assessment is up to date if known to services.

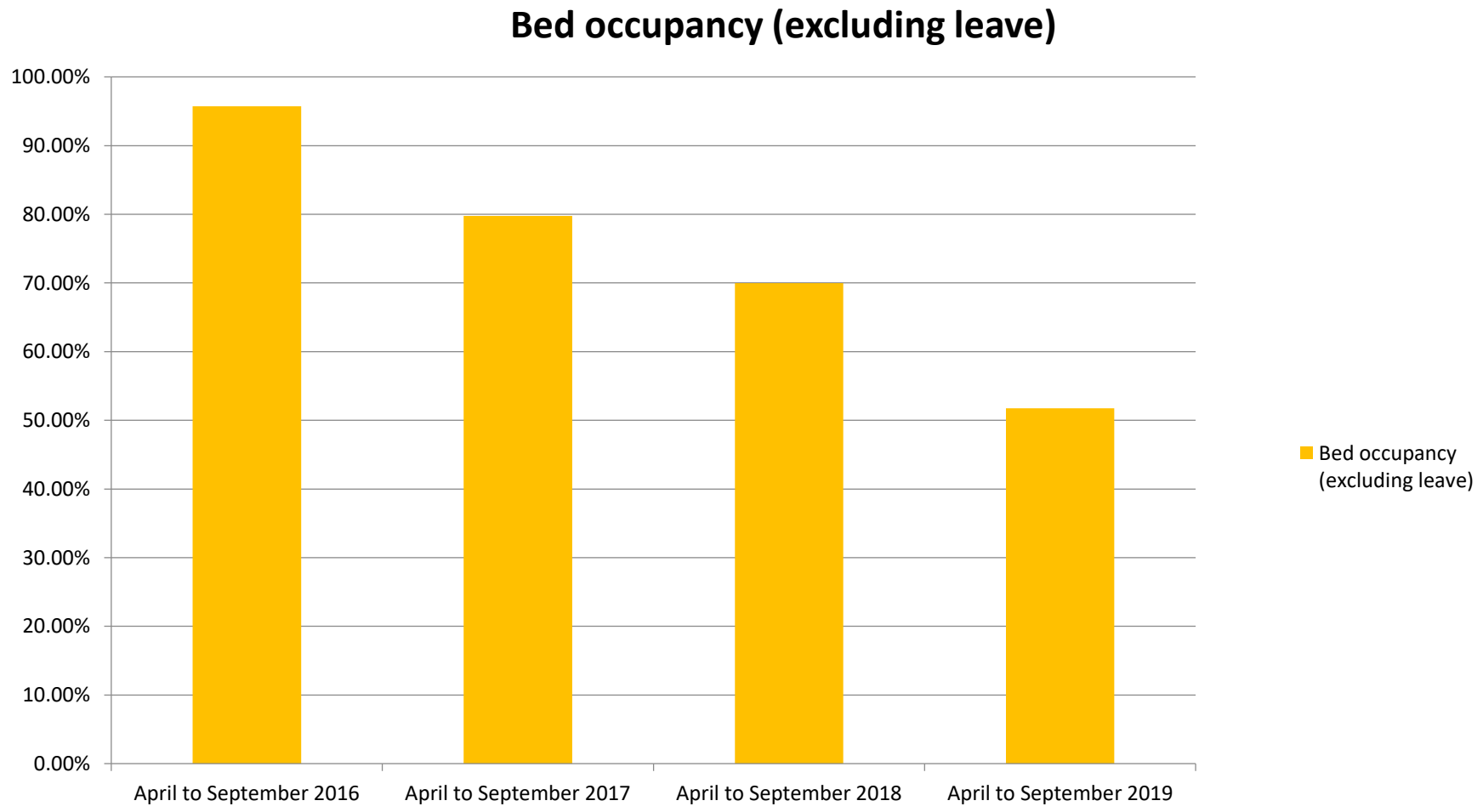
The Care Plan
Where known to services the care plan must include key areas:

Physical health, Aggression, Present and historical risk, Behaviour patterns, Environmental Risks, Communication Strategies

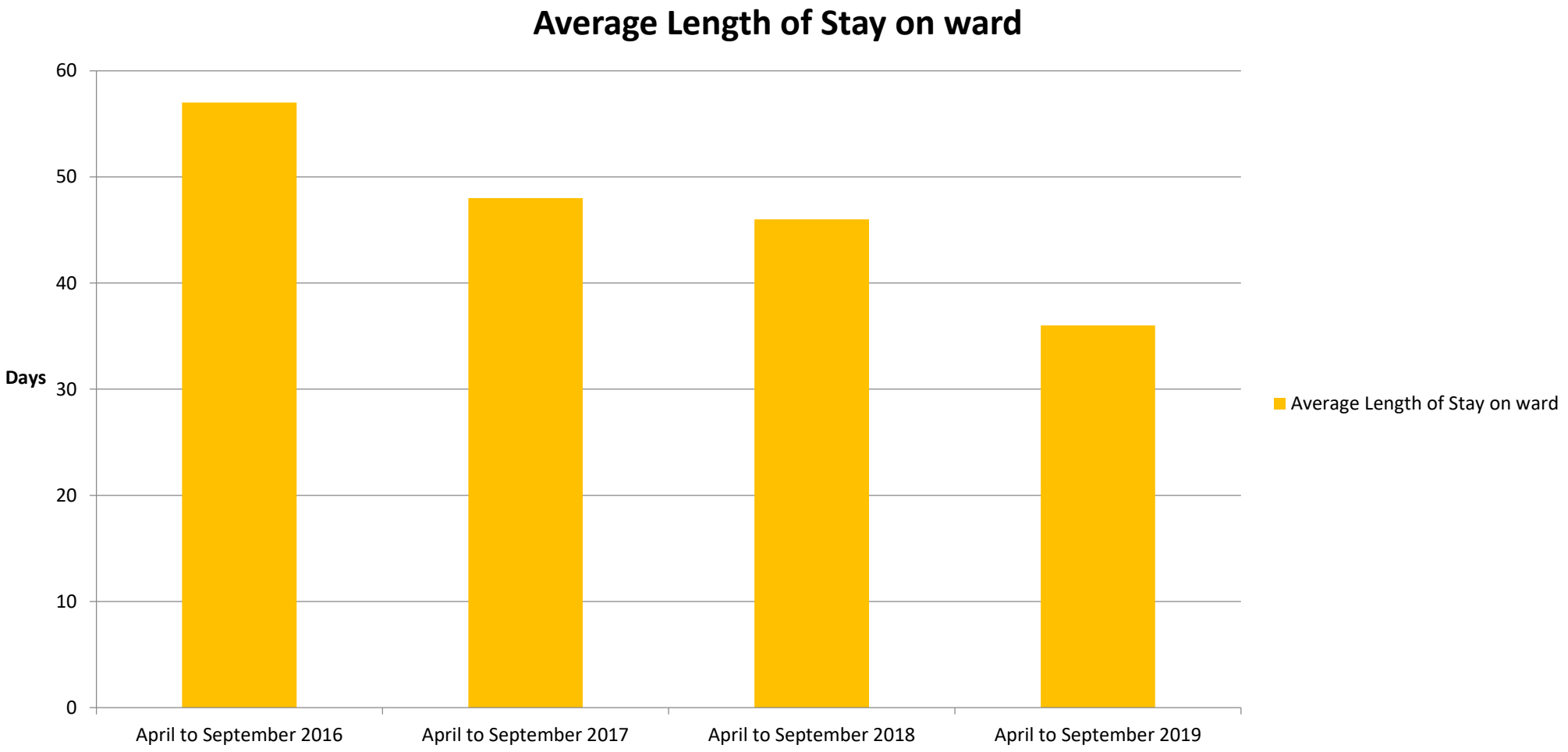
Hospital Avoidance Criteria

- Patient must have a confirmed diagnosis of dementia.
- Updated care plan if known to services which identifies the need for input from Hospital Avoidance.
- Recent risk assessment.
- Evidence of recent input if open to a pathway.
- To carry out emergency visits when required and refer on to appropriate professionals for further input

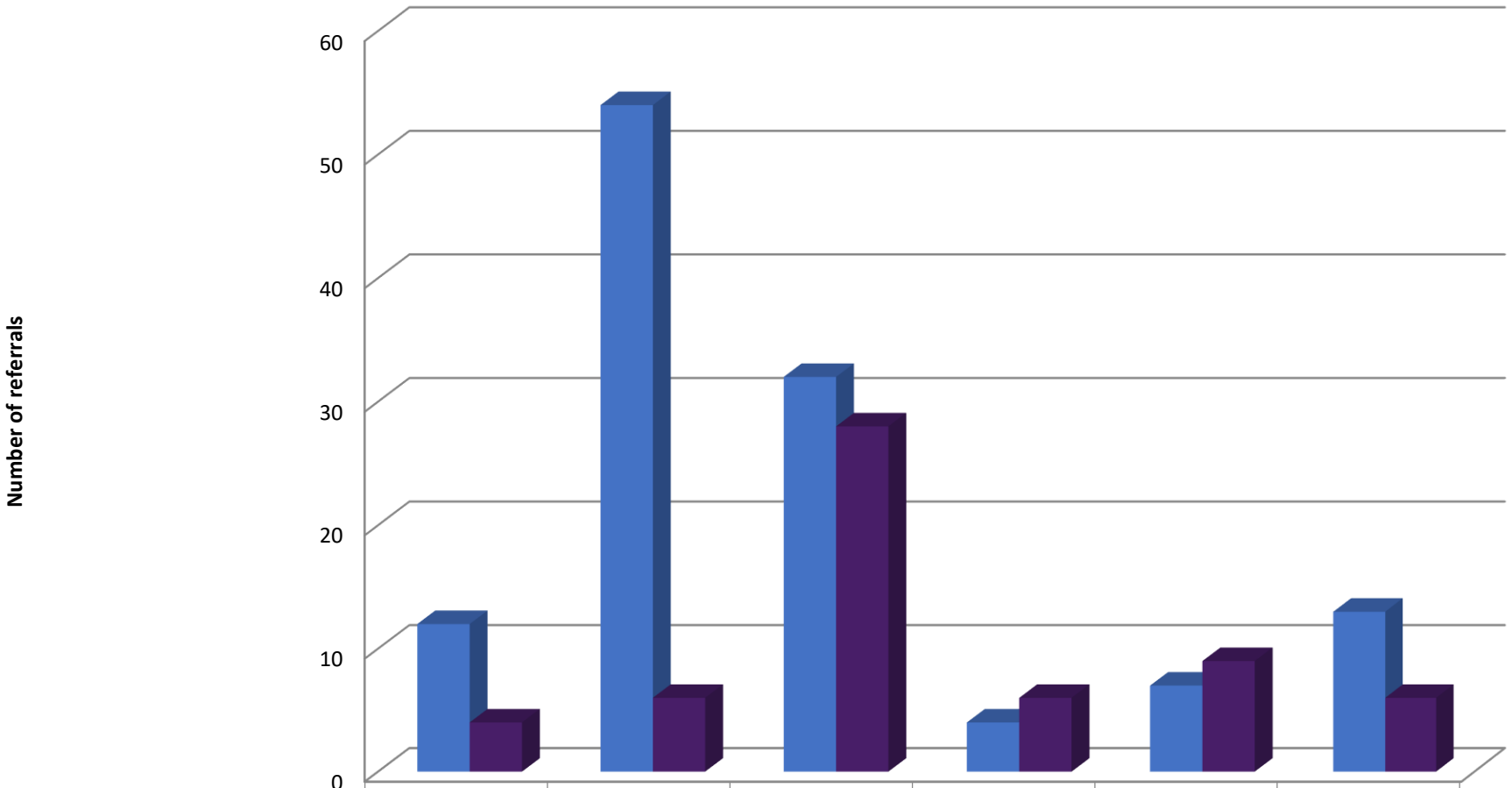
Evidence


Bed occupancy (excluding leave)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
April to September 2016
April to September 2017
April to September 2018
April to September 2019
Bed occupancy (excluding leave)

Evidence

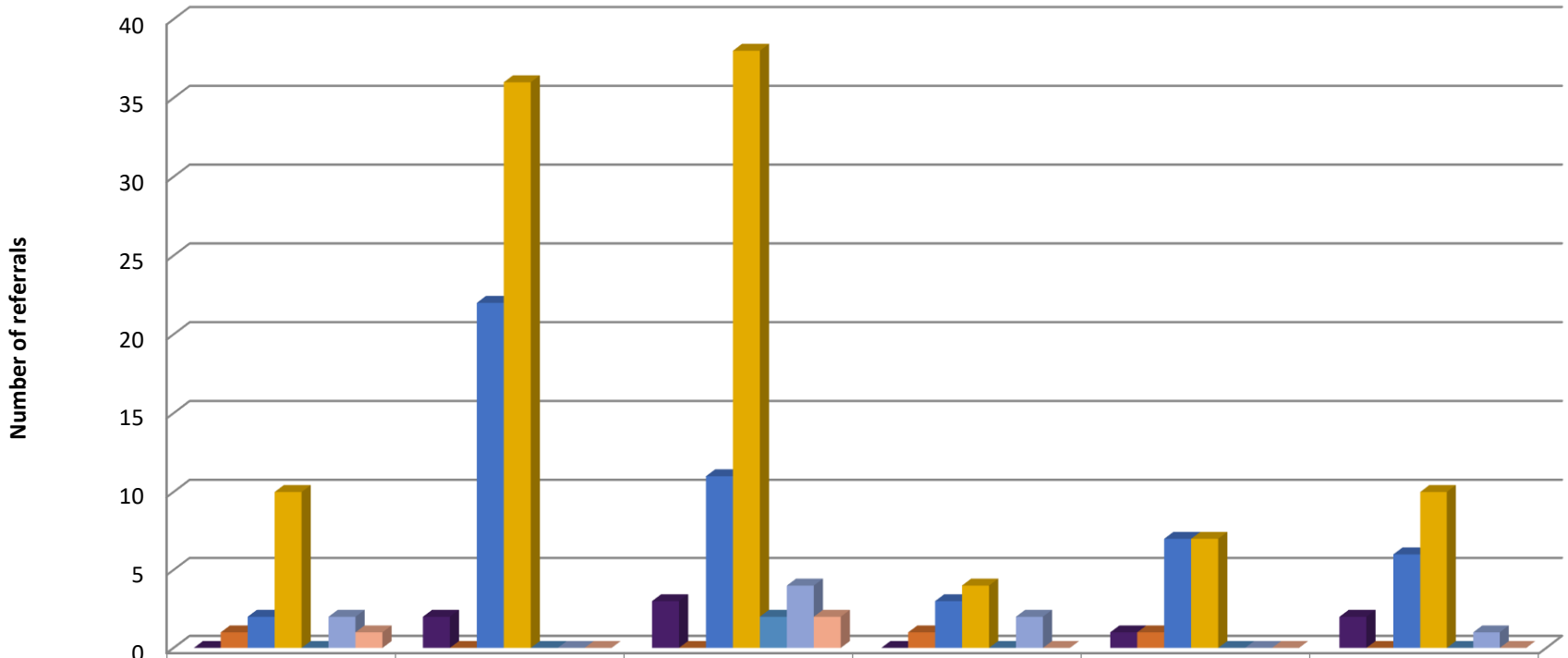

Average Length of Stay on ward
60
50
40
30
20
10
0
Days
April to September 2016
April to September 2017
April to September 2018
April to September 2019
Average Length of Stay on ward

Hospital Avoidance - Source of referral (April to September 2019)



	April	May	June	July	August	September
Patients referred fom care homes	12	54	32	4	7	13
Patients referred from own home	4	6	28	6	9	6

Hospital Avoidance - Area source of referral (April to September 2019)



	April	May	June	July	August	September
Oswestry	0	2	3	0	1	2
Whitchurch	1	0	0	1	1	0
Shrewsbury	2	22	11	3	7	6
Telford	10	36	38	4	7	10
Bridgnorth	0	0	2	0	0	0
Ludlow	2	0	4	2	0	1
Other	1	0	2	0	0	0

Case Study A (prior to commencement of Hospital Avoidance)

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- Male patient admitted to hospital on Section 2 of the MHA in August 2014. He was known to the memory team and recently had a diagnosis of dementia.
- Patient history: living at home with wife, had 2 children and had driving licence which he used. The family believed he had memory problems.
- Patient became paranoid towards his wife and 11 year old neighbour's son and also displayed signs of aggression towards his wife.
- Medication had been commenced with very little impact six weeks prior to admission.

Case Study A

- Patient saw himself as still being in the police force and whilst on the ward he became aggressive and threatening to both fellow patients and staff.
- Patient was discharged to a nursing home after 6 weeks in hospital. The family were unhappy as they felt the home would not manage him and his presentation.
- Patient remained at the home for a period of 1 year, however he was readmitted on a Friday evening in March 2016 under Section 3 of the MHA. The family were angry that he required admission at the weekend and again a change of environment.
- If Hospital Avoidance had been in place then the home would have been supported with visits and phone calls. This would have given ward staff opportunity to show the home how to manage the presentation, and would have reduced the anxiety and distress of both patient and family.
- Additionally a post-discharge support plan (ranging from 2 weeks to 1 month) would have been introduced to support the home and patient in order to prevent readmission to hospital.

Case Study B

- Patient was a 76 year old gentleman living alone in North Shropshire. He had no family or next of kin involved in his care. The patient was open to the memory service in 2017 but no active input due to him being identified as functional.
- Following an MHA a social worker visited the patient with an attempt of setting up a care package but it was felt unsafe due to the patient being suspicious, hostility and aggression had increased and staff stated they felt threatened.
- An MHA was carried out with a recommendation for a Section 2. A referral was subsequently made for Hospital Avoidance.

Case Study B

- Over the next couple of weeks Hospital Avoidance supported the patient through home visits, telephone calls and advice with medication.
- Through this support the patient became less suspicious and aggressive, and also more trusting of healthcare professionals.
- He accepted respite care and was moved to the placement. Subsequent confirmed diagnosis of Alzheimer's disease.
- In conclusion had Hospital Avoidance not been actively involved, this gentleman would have been sectioned, admitted to an acute dementia ward which would have had a detrimental effect to his well-being. His health and physical needs have been met in a more appropriate environment.

Discharge to Assess (D2A)

- The D2A pilot commenced 15th October 2018 following success of Hospital Avoidance
- This involves Shropshire CCG utilising capacity within commissioned beds on Oak Ward (4 beds).
- The beds are used when patients in acute hospitals are medically fit and require an assessment for placement to either return home or future care.
- The expectation of this role is that the patient will be reviewed, assessed, diagnosed (if required), treated and future care needs identified through nursing and occupational therapy assessments.

Discharge to Assess (D2A)

- Improved outcomes for patients
- Releasing beds for acute care
- Reducing length of stay in hospital beds where patients can quickly clinically deteriorate and those with cognitive impairments can see their confusion increase
- Assessment at the right time in a person's recovery with the skilled multidisciplinary team to determine longer term needs
- A structured, quieter and therapeutic environment outside the acute hospital allowing a period of recovery and assessment.
- A potential reduction in the premature and/or inappropriate use of residential care.
- Reduced costs of on-going care packages and care home placements for individuals themselves, LAs and CCGs

Discharge to Assess (D2A)

- From 18/01/19 – 10/10/19 the D2A pilot has seen 19 patients admitted to Oak.
- 6 have been discharged and 1 patient is a current inpatient.
- The average length of stay for the discharged patients was 21.8 days.
- All patients were offered post-discharge support from Oak ward in order to facilitate a smooth transition and prevent readmission.

The Future

- Hospital Avoidance to be expanded to seven days a week
- Referrals will be sent to a generic Hospital Avoidance e-mail address when known to services.
- When referrals received from Community Memory Services the Gold Standard Care Plan must be followed
- Raise the profile of hospital avoidance
- To promote referral from an early point, as soon as there is a risk of the situation escalating towards an MHA.
- Patient to be seen by a qualified nurse from the Home Treatment Team prior to considering referral to Hospital Avoidance unless it is an emergency

Any Questions?