ONE CHANCE TO GET IT RIGHT: EXPLORING PERSPECTIVES ON DECISION-MAKING FOR DISCHARGE TO CARE HOME

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Thursday 28th March 2019

PRESENTATION OVERVIEW

- Context: policy and previous work
- Methods and recruitment
- Findings:

- Roles
- Context of the decision
- Communication

- Conclusions and implications for multidisciplinary practice
- Next steps

CONTEXT

Health and Social Care Integration
Public Bodies (Joint Working) (Scotland) Act 201

Core Suite of Integration Indicators

21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home

National Health and Wellbeing Outcome:

People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Rationale for Indicator

This indicator represents the fact that the policy direction is to reduce the occurrence of people being placed directly into care homes from hospital without due consideration being given to more appropriate alternatives that suit the needs of individuals.

THE 'GIBSON TRUST' PROJECT

AIMS:

- Examine the decision-making processes involved in discharge to a care home
- To establish the role of undiagnosed dementia, cognitive impairment and delirium in these processes

- Funded by Alex and Elizabeth Gibson Trust

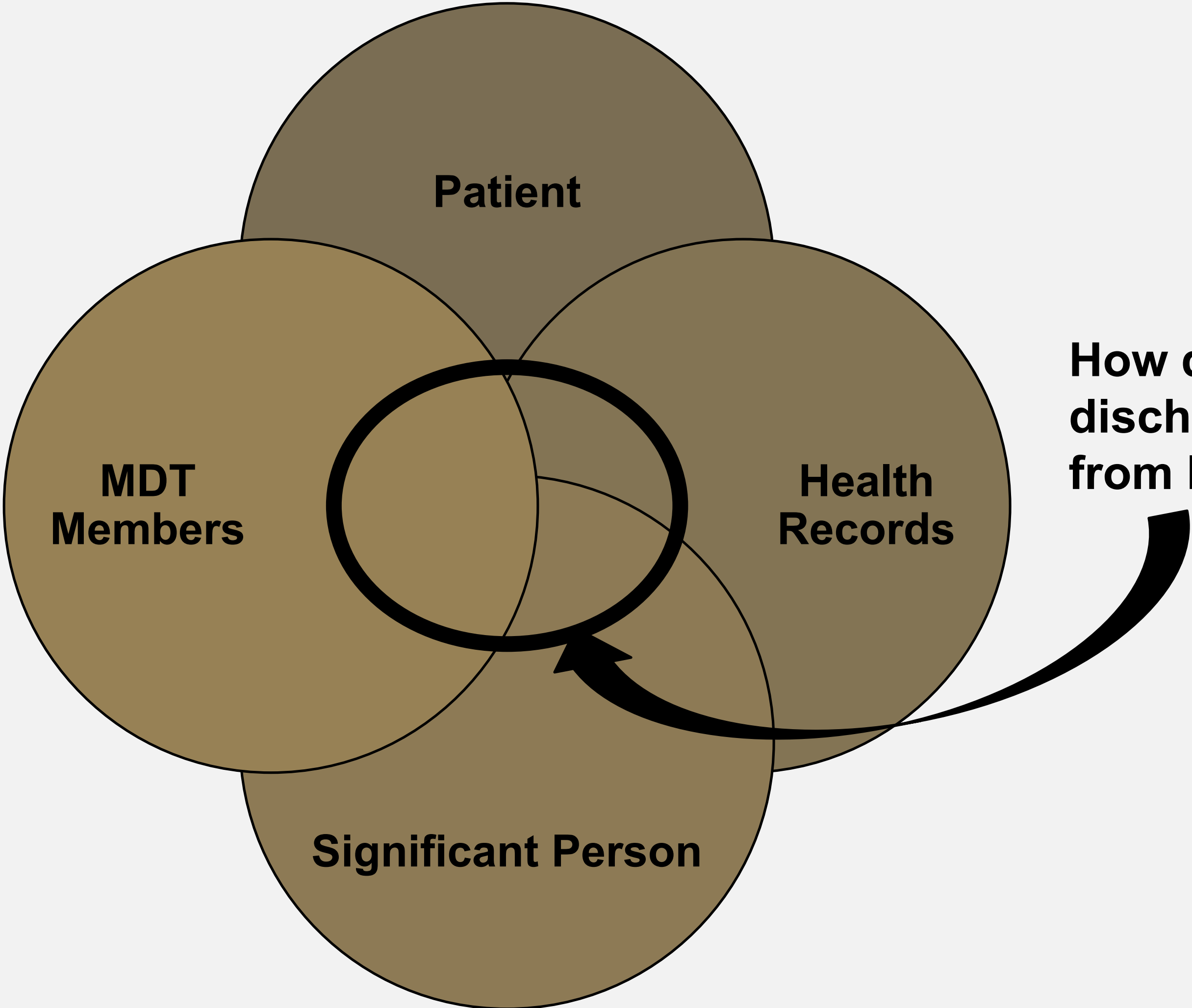
- Study period: **Admitted November 2013 – February 2015**
- Data extraction: April 2015 – September 2015

METHODS:

- Retrospective cohort study, n=100, consecutive cases sought
- Individuals admitted to one acute hospital and **newly admitted to a care home** at time of discharge
  - No comparison group of people discharged home
- Case-note review
- Data extraction by single researcher
- Quantitative & qualitative measures to inform:
  - Descriptive analyses
  - 10 detailed case-studies

ONE CHANCE TO GET IT RIGHT: EXPLORING PERSPECTIVES AND EXPERIENCES IN CARE HOME DISCHARGE DECISION-MAKING

Case study research:
uses a range of data sources to explore phenomena from different perspectives

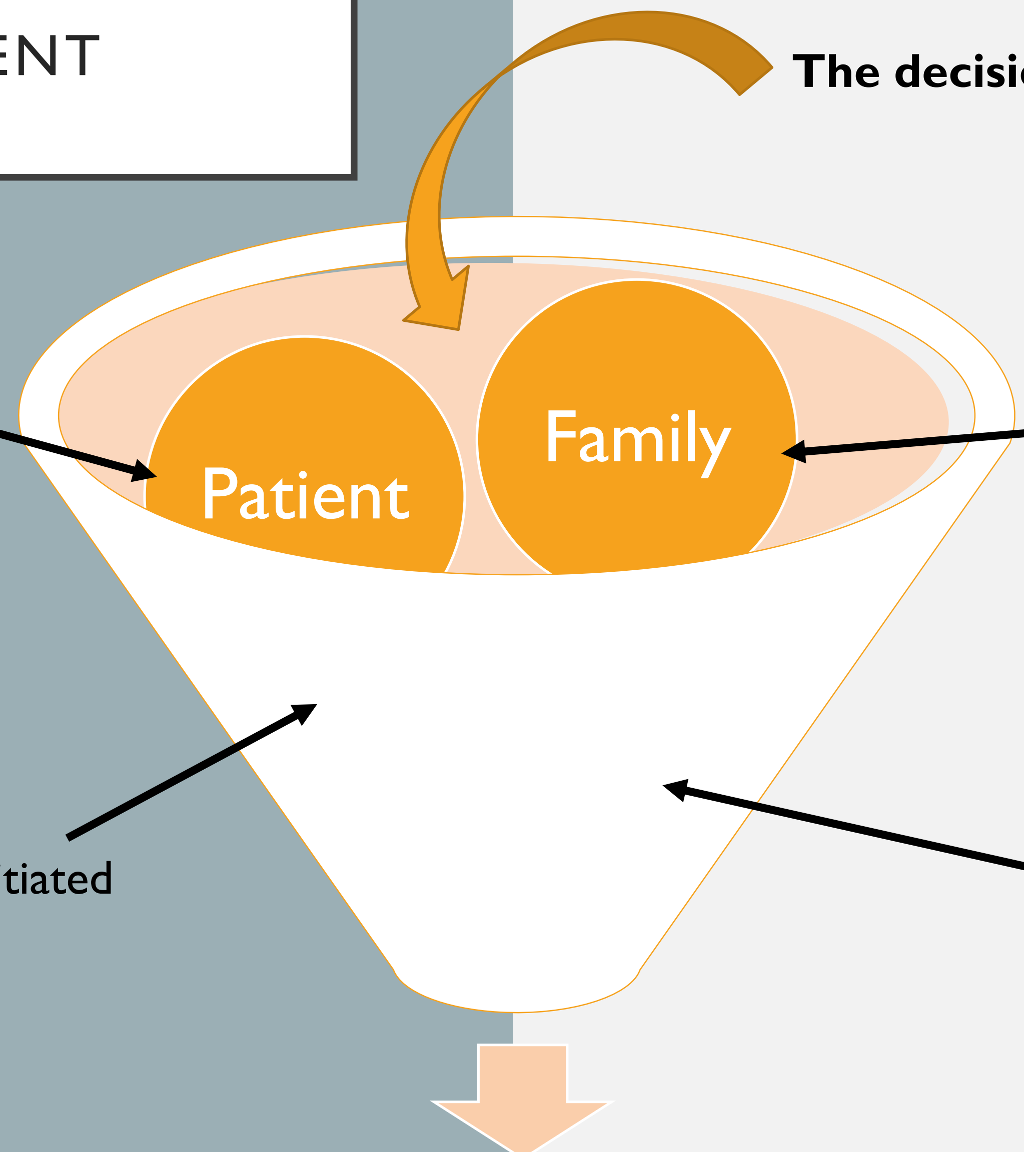


How decisions are made to discharge patients directly from hospital to care home

RECRUITMENT

6 Adult Patients

- From two acute hospitals
- Variation between sudden decline in function (e.g. through stroke) and gradual decline



7 Significant Persons

- Daughter (3)
- Nephew (1)
- Sister (1)
- Partner (1)
- Step son (1)

Variation in who initiated the decision

- Patient
- Family
- MDT

17 MDT Members

- Consultant (5)
- Junior Doctor (1)
- Social Worker (4)
- Occupational Therapist (1)
- Physiotherapist (3)
- Nurses (3)

6 Data Sets

FINDINGS: ROLES

A Perceived Burden:

Isa: ***"See, I'm not wanting to upset my daughter, she's been a good daughter…..I was thinking of my daughter, the trouble that I was going to give her trying to look after me….And that's what made me say well, the best place is…a nursing home."***

Arthur: ***"Just to be safe, be safe and no be a trouble to my family…"***

Peter: ***"Mainly because the family were worried about me and I didn't want that. I didn't like the idea of going into a care home, but I realised it probably was the only way to stay out of hospital and stay well."***

FINDINGS: ROLES

The Significant Person's Expectations:

Peter's daughter: ***"We just felt he wouldn't manage at home and we would just be worrying about him all the time."***

Isa's daughter: ***"She stays in [place name] which is an hour and a half from us……Which is fine…..we've been doing it for years…..But if in an emergency, it's not really been advisable and it, you know, it's no good to my mum really. I can't just say, 'Right, Mum, I'll be there in five minutes'."***

FINDINGS: ROLES

Professional Expectations:

Agnes' Consultant: ***"I think it would have needed probably an increase in her already substantial package of care……and I think with the support of her family that would have been feasible."***

Arthur's Physiotherapist: ***"if the circumstances would have been different and his sister would have been heavily involved and readily involved, then no, we could have supported him at home. But he just lacked the support…."***

Robert's partner: ***"And the consultant said to me, he says, 'I notice', he says, 'that you're going to take him home to care for him'. I went, 'aye'. He says, 'it's not an option'. He says, 'he needs far, far too much care'."***

FINDINGS: ROLES

Professional Division in Roles and Responsibilities:

Agnes' Consultant: ***"You're trying to guide people through decisions where you don't really have all the information…."***

Agnes' OT: ***"I know…there's a lot of things we are not a hundred percent on and it's definitely not my area of expertise and we don't like to say anything that maybe wrong."***

Peter's Nurse: ***"We're making sort of promises and plans when we haven't got the expertise."***

Harry's Consultant ***"I'm sometimes involved in the initial discussions with social work and family……I don't feel confident enough, I don't know the details and I don't think it's……necessarily my role to delve in to those details with them."***

FINDINGS: THE CONTEXT OF THE DECISION

Time and space

Harry's consultant: *"there's always pressure to move people on, but there was no pressure for him. I didn't feel any pressure in making the decision….."*

Makes difficulties 'public'

Permits conversations

Socially acceptable discussion

Limits preferences

Agnes: *"I told him that I would like to go to [care home name]. Nowhere else but [care home name], because it's near hand and everything…"*

Significant point in the journey

A temporary arrangement

Robert's social worker: *"when I spoke to him….I was thinking 'he thinks it's only going to be for a short time'. And again, the way I would play it is that we do our review after 12 weeks. So when I go back, if he expects to go back home, then we have that conversation at that point."*

FINDINGS: COMMUNICATION

People want to discuss the decision!

Little opportunity to discuss range of emotions

Peter: *"The staff haven't bothered very much really* [about talking about the decision]....

Arthur: *"Probably, could have, well, a meeting like this would be handy."*

Harry's nephew: ".....what could have made it helpful, better? Simply brief discussions like this, a brief meeting so that [Harry] was very clear about what the next steps were."

FRAGMENTED PROCESS

Agnes' Consultant: ***"You're trying to guide people through decisions where you don't really have all the information…."***

Agnes' OT: ***"it's definitely not my area of expertise and we don't like to say anything that maybe wrong."***

Peter's Nurse: ***"We're making sort of promises and plans when we haven't got the expertise."***

Harry's Consultant: ***"But I don't view it as……I don't feel confident enough, I don't know the details and I don't think it's my….necessarily my role to delve in to those details with them."***

Discharge to care home:

IMPLICATIONS FOR MULTI-DISCIPLINARY PRACTICE

Complex process - needs careful consideration by staff.

Need for enhanced knowledge around discharge to care home process

Emotional and psychological support, effective communication

Honesty and transparency

Shared professional responsibility

Person-centred discharge to care home

NEXT STEPS

Publications: In progress!

Quality Improvement Project:

- Local initially
- Aims to improve communication with patients/families when considering care home

PhD:

- Exploring the discourses of the discharge of older people from the acute hospital and the implications for person-centred discharge practice.