Long stays in hospital for people with disabilities: is this the right care at the right place?

Judith Burton
Helen Redfern, Helen Seiffert, Bob Lonne
Overview

- Discharge delays – not good for patients or the hospital system
- The practice improvement project at a Queensland hospital
- What we found out about patients with disabilities who had long stays in the acute hospital setting
- How to improve care and discharge planning for these patients
Discharge delays

Long hospital stays are not in patients’ best interests
- Physical health and well being
- Mental health and well being
- Family / carer experience

Long hospital stays are costly to government / community
- Health ‘reform’ agenda
- Quality care provision: right care, right time, right place
- Access to acute care when needed
The Practice Improvement research

A central issue for hospital services - providing care for adults with disabilities beyond the acute treatment phase because they are unable to return to previous living situation.

Problems identified but little data to clearly describe these patients or provide evidence for changes to practice.

Social work services in collaboration with Patient Flow unit.
The research

- Adults with Disabilities Pathway (2009 – 2012)
- Audit of clinical data on these 80 patients
- Interviews with five social workers
- Interviews with five members of a multi-disciplinary team (OT, Dietician, Physio, Speech Pathologist, Nurse Unit Manager)
Acute care

Deemed as active treatment relating to the **Principal Diagnosis** which is the diagnosis chiefly responsible for admission.

Sub acute care includes:
- Rehabilitation
- Geriatric evaluation
- Palliative care
- Psycho-geriatric care

Sub acute care Maintenance

**Patient discharge**
- Home
- Community care
- Residential facility

**Episode of care**

Patient admission

Patients enter the *Adults with Disabilities Pathway* at this point
<table>
<thead>
<tr>
<th>Existing Primary Disability Group</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Intellectual</td>
<td>15</td>
<td>18.8</td>
<td>18.8</td>
<td>18.8</td>
</tr>
<tr>
<td>Physical</td>
<td>1</td>
<td>1.3</td>
<td>1.3</td>
<td>20.0</td>
</tr>
<tr>
<td>Acquired Brain Injury</td>
<td>3</td>
<td>3.8</td>
<td>3.8</td>
<td>23.8</td>
</tr>
<tr>
<td>Neurological</td>
<td>4</td>
<td>5.0</td>
<td>5.0</td>
<td>28.8</td>
</tr>
<tr>
<td>Vision</td>
<td>1</td>
<td>1.3</td>
<td>1.3</td>
<td>30.0</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>13</td>
<td>16.3</td>
<td>16.3</td>
<td>46.3</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>5.0</td>
<td>5.0</td>
<td>51.3</td>
</tr>
<tr>
<td>No pre existing disability</td>
<td>39</td>
<td>48.8</td>
<td>48.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Existing Primary Disability Group</td>
<td>Adult with Disability Pathway total length of stay</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 - 50 days</td>
<td>51-100 days</td>
<td>101-150 days</td>
<td>151 -200 days</td>
</tr>
<tr>
<td>Intellectual</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Physical</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Acquired Brain Injury</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Neurological</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Vision</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>No pre existing disability</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>10</td>
<td>11</td>
<td>3</td>
</tr>
</tbody>
</table>
Two patients’ journeys

‘Scott’ was 58 years old and had an intellectual disability and mental health problems. Admitted in April (09) due to decline in mental health / behavioral issues, unable to return to family, medically stable Dec (09), MH court Feb (10), was not a ‘current’ client of DS June (10), search for supported accommodation July (10), discharge to group home Nov (10).

Length of stay – 20 months (about 7 mths after acute care needs met)

Services / systems involved: two hospitals, clinical psych, Mental Health court, case manager, Disability Services, Dept. directors, three community agencies
Two patients’ journeys

‘Felicity’ was 37 years old with intellectual disability, epilepsy and physical injury. Admitted post alleged assault from partner Jan (10), stayed to control epilepsy, capacity issues noted and assessment undertaken Feb (10), DS assessment and move to Extended Care unit March (10), eligible for DS accommodation but $$?, accommodation located April (10), ongoing transition to group home pending funding from DS, discharge June (10)

Length of stay – 6 months (about 4 after acute needs met)

Services / systems involved – the hospital (inc several specialists), DS, QCAT
Staff views re meeting needs

- Case complexity – holistic view
- Multidisciplinary work vital
- Efforts to include patient / family in decisions
- Social work and systemic practice
- Relationships with government (esp. disability services) and community agencies
- Funding and accommodation constraints
- Carer stress and next-level-of-care options
Implications for hospital workers: Strategies to reduce length of stay

- Early intervention and referral inc. supports for carers / family
- Advocacy support mechanisms at systems and client level
- Enhanced care coordination – hospital management issues
Conclusion

- The journey through hospital for adults with disabilities can be difficult as new health issues interact with existing disabilities.
- Discharge also complicated by current lack of accommodation options or in-home supports.
- Collaboration and systems practice can effect better patient outcomes.
Questions and comments
Speaker contacts

- Judith Burton
- School of Public Health and Social Work
- Faculty of Health
- QUT
- j.burton@qut.edu.au